

NOTICE OF PRIVACY PRACTICES
Abridged Edition

Effective April 14, 2003, the Department of Health & Human Services has implemented protection for patient health care information. It outlines who we may disclose information to without your authorization and how we can disclose your protected health information with your authorization as well as how you can gain access to your personal health information or to make a complaint to the Department of Health & Human Services if you feel your protected health information was used in an improper way. This notice will give you a brief description of our entire privacy practices.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

So that this office can treat you, receive payment for that treatment and run our health care operation, we may use your protected health information without your authorization to send to third party payers, administrators, etc.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT MAY BE MADE WITH YOUR WRITTEN AUTHORIZATION

With your signed authorization we may make communications with you to promote products and services that may not be for a specific purpose of providing treatment advice. You have the right to revoke this authorization. Other permitted and required uses and disclosures that may be made without your authorization or opportunity to object – we may disclose to a member of your family, a relative, a close friend or other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also disclose your protected health information to an authorized public or private entity as required by law.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations:

- Required by law
- Health Oversight
- Legal Proceedings
- Research

Your rights – You may inspect or obtain a copy of your protected health information for as long as we maintain that information unless protected by federal law.

RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

You may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operation. Also, you may request that any part of your protected health information not be disclosed to your family members or friends who may be involved in your care. Your request must be in writing and state specific restrictions requested and to whom it applies.

RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATION FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION

You may request that you receive these communications from us at an alternative location or by alternative means than is normally provided to other patients.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION

You may request an amendment to your protected health information for as long as we maintain your protected health information. In certain cases we may deny your request for an amendment.

RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE

You have the right to receive an accounting if we receive a request for disclosure of information for purposes other than treatment, payment and health care operations.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE

You have the right to receive a complete copy of our privacy practices by paper or electronically.

COMPLAINTS

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health & Human Services.

This notice was published and becomes effective April 7, 2003.

**CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND
HEALTHCARE OPERATIONS**

I acknowledge that Chiropractic and Alternative Health Services, P.L.L.C. "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Chiropractic and Alternative Health Services, P.L.L.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractic and Alternative Health Services, P.L.L.C.

The Notice of Privacy Practices for Chiropractic and Alternative Health Services, P.L.L.C. is also provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Chiropractic and Alternative Health Services, P.L.L.C. duties with respect to my protected health information.

Chiropractic and Alternative Health Services, P.L.L.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing, except to the extent that Chiropractic and Alternative Health Services, P.L.L.C. has taken action in reliance on this consent.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this notice, and my understanding and my agreement to its terms.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority