# FRIEDMAN CHIROPRACTIC, INC.

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## PRIVACY CONFIDENTIALITY STATEMENT

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

**INFORMATION DISCLOSED BY THIS OFFICE**

We may disclose information to other health care professionals and/or your insurance carrier for treatment, payment, or health care operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as any legal proceedings. We reserve the right to contact a family member or other authorized person in the event of an emergency. However, information will not be disclosed without a patient's expressed written consent unless compelled to do so by legal authority. We will contact you by phone or mail in the event a request for information is made.

Please note that if it becomes necessary to call your home concerning an appointment or health matter, we will not leave a message on an answering machine or with any other person than yourself that discloses confidential information. If you would prefer that we use an alternate number to reach you, please let us know.

**PATIENT RIGHTS**

1. You may send us a request in writing to see or have a copy of any information we have on file about you. You may amend any incomplete or inaccurate personal information. If the information came from another source, we will refer you to that source, such as hospitals or health care workers.

2. You may request that we place additional restrictions on how we may use, and to whom we may disclose your health information. However, we are not legally required to agree to your request, in particular, instances where they may be prohibited by law.

3. You may request us to use reasonable alternative means of contacting you regarding medical matters or direct us to an alternate address.

4. You may request an accounting of any disclosures concerning your medical information, except when these are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

5. You have the right to see and receive a copy of your health information. After the first copy there will be a $25 charge for additional copies.

6. You have the right to amend your information. We reserve the right to disagree with your changes. In the event of a disagreement, we will provide you with information about our denial of your amendment and the means with which you may appeal it.

7. You have the right to a copy of the notice upon request.

**ADDITIONAL INFORMATION**

If you have any questions about your rights to privacy or complaints as to how your privacy is handled by this office, please contact our privacy officer at (415) 459-4646. If you are not satisfied with the way your complaint is handled, you may contact DHHS (Office of Civil Rights), 200 Independence Ave., S.W., Room 509F, HHH Building, Washington, D.C. 20201.

I have read this Privacy Confidentiality Statement and understand my rights contained in it. By signing below, I give you authorization and my consent to use and disclose my protected health information as noted herein.

Patient Name (print) ______________________________________________

Signature: ______________________________________________________ Date: ____________________