Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE,

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.

2. You are entitled to see your medical records.

3. You are entitled to receive a copy of your medical records. There is a fee for this service.

4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)

5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.

6. The doctor has a right to a rebuttal to the patient's disagreement. Any time a file is sent out of the office, a copy of that rebuttal must be included in the file.

7. You have the right to specify how access to your health information is restricted and from whom.

8. You have the right to indicate the method, phone numbers and addresses to which telephonic and written communications to you shall be sent.

9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.

10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization, except as covered under applicable law. You have a right to receive upon request, an accounting of any disclosure of personal health information not made for treatment, reimbursement or administrative purposes as described above, or otherwise excepted by law.

11. You are entitled to this practice's best efforts to maintain the security of Personal health Information on your behalf within and outside this office.

12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.

13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.

14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at toll free: 1-877-696-6775 or E-Mail: ww.hhs/gov/ocr

PATIENT'S AFFIRMATION OF RECEIPT
OF PATIENT'S STATEMENT OF PRIVACY RIGHTS

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

I authorize League City Chiropractic to discuss my treatment and/or billing with:

_____ _____
Name Relationship

_____ _____
Name Relationship

Affirmed,

_____ _____
Patient Signature Patient Printed Name

_____
Date