

## STATEMENT OF PRIVACY PRACTICES

We are dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. We are committed to ensuring that your health information is never compromised. We may amend our policies and practices but will always inform you of any changes that might affect your rights.

### Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our chiropractic care operations. Your personal health information will never be otherwise given to anyone – even family members- without your consent. You, of course, may give written authorization for us to disclose your information to anyone you choose.

Our office and electronic systems are secure from unauthorized access and we are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

### Collecting Protected Health Information

We will only request personal information needed to provide our standard of high quality chiropractic care, implement payment activities, conduct normal chiropractic practice operations, and comply with the law. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

### Disclosure of Your Protected health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, emails and postcards.

### Patient Rights

You have a right to request copies of you healthcare information; to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the US Department of Health and Human Services.

I give permission to Dr. McCown to discuss my protected healthcare information with

\_\_\_\_\_.

We thank you for being our patient. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_