HANSON FAMILY CHIROPRACTIC
NOTICE OF PRIVACY PRACTICES

Hanson Family Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Hanson Family Chiropractic."

"It is our policy to provide a substitute health care provider, authorized by Hanson Family chiropractic to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."

"On occasion, incidental disclosures of health information may occur such as ongoing routine details of care discussed within earshot of other patients and staff."

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Hanson Family Chiropractic for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as, identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to corners or medical examiners.

Organ Donation
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Governmental Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> "As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
> "Communication may also include newsletters, birthday cards, reminder/recall for appointment, thank you for referrals, etc."

Complaints
Complaints about your Privacy rights or how Hanson Family Chiropractic has handled your health information should be directed to Joanne Kindt/Pamela DeLaCruz by calling this office at 415-924-6500. If Joanne Kindt/Pamela DelaCruz is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Hanson Family Chiropractic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE
HANSON FAMILY CHIROPRACTIC

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of Hanson Family Chiropractic's "NOTICE OF PRIVACY PRACTICES".

Hanson Family Chiropractic has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that Hanson Family Chiropractic has included a provision that it reserves the right to change the terms of its notice and to make the new notice effective for all protected health information that it maintains.

Requests:

- ❑ I wish to file a "Request for Restriction" of my Protected Health Information.
- ❑ I wish to file a "Request for Alternative Communications" of my Protected Health Information
- ❑ I wish to object to the following in the "Notice of Privacy Practices".

_____
_____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

_____ _____
Signature Date

_____
Print Name

_____
(Office Use Only)

Signed form received by:_____ Date_____

Good faith effort to obtain receipt:
(Describe)_____

_____

_____