NOTICE OF PRIVACY PRACTICES

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.

All requested information shall be relevant to the care and well-being of the individuals served. All information should be considered Protected Health Information (**PHI**) in accordance with the Federal Health Insurance Portability and Accountability Act (**HIPPA**) of 1996.

Signature of this Privacy Notice shall serve as acknowledgement that **Heights Atlas Orthogonal Chiropractic Clinic** may use and share information for treatment, payment and overall healthcare operations that may include counseling, billing and quality assurance. The use or sharing of any information not directly related to services and supports shall have prior written authorization.

An example of information sharing, that may be necessary, without written consent or authorization is a life threatening medical emergency.

RIGHTS OF THE INDIVIDUAL. The individual, in writing, may request restrictions on the use or sharing of the information, receive confidential communication, inspect and receive copies of any shared information, receive an accounting of shared information and amend or revoke authorization.

DUTIES OF HEIGHTS ATLAS ORTHOGONAL CHIROPRACTIC CLINIC. Maintain privacy and provide notice of legal duties and privacy practices. Abide by this effective notice and any restriction agreements. Provide notice of revised privacy practices.

For additional information or complaints regarding privacy practices contact the **HIPPA COMPLIANCE OFFICER,** Connie Lang, D.C. at 785-354-8909.

Complaints against Heights Atlas Orthogonal Chiropractic Clinic, regarding privacy of PHI should be forwarded to:

Department for MH/MR
(502) 564-4527

or

US Dept of Health and Human Services:
200 Independence Avenue, SW Room 509F
HHH Building
Washington, DC 20201
1-800-368-1019

This notice has been issued and considered effective _____. This document shall be retained by Heights Atlas Orthogonal Chiropractic Clinic for a minimum of six (6) years.

_____ _____
Signature (Patient) DATE Signature (Representative) DATE

_____ _____
Signature (Witness) DATE Relationship to Client