Dr.Charles T Pershing JR DC

Dr. James O Gordon DC

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.

"Protected health information" or "PHI", is information about, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PHI

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services, including with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining payment of our claim to your insurance company may require that your relevant health information be disclosed to the health plan to obtain payment.

Healthcare Operations: We may use or disclose your PHI to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical professionals, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical professionals who assist us in patient care. We may also call you by name in the waiting room when our physician or technician is ready to see you. We may use or disclose your PHI to contact you to remind you of your appointment.

Required by Law: We may use or disclose your PHI without your authorization as required by law. **Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, but that will not affect any action taken in reliance on the authorization.

YOUR RIGHTS

You have the right to inspect and copy your PHI except the following per federal law: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, stating the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right upon request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request.

You may have the right to have your PHI amended. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our phone number listed on this document.

I acknowledge receipt of this notice:

Sign: _____ Date:_____

Print patient name: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____