KOKOMO CHIROPRACTIC, PC

824 BELVEDERE DR.
KOKOMO, IN 46901

PRIVACY DISCLOSURE STATEMENT

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in this facility on each visit. We need this record to provide you with quality care and to comply with certain legal requirements.

The following categories describe different ways that we use and disclose medical information.

Information that may be disclosed about you:

1) **FOR TREATMENT**: We may use medical information about you to provide you with medical treatment or services. We may disclose this information to other members of our staff who will be involved in treating you. We also may disclose medical information about you to people outside the clinic, such as family members who may be involved in your care.
2) **FOR PAYMENT**: We may use and disclose medical information about you so that treatment and services you receive may be billed to and payment collected from you, an insurance company or other third party. We may also need to get prior approval from your health insurance for recommended treatment.
3) **HEALTH RELATED BENEFITS AND SERVICES**: We may use and disclose medical information to tell you about or recommend possible treatment options or services that may be of interest to you.
4) **AS REQUIRED BY LAW**: We will disclose medical information about you when required by Federal, State or Local Law.
5) **WORKERS COMPENSATION**: We may release medical information about you for workers compensation or similar programs that provide benefits for work-related injury or illness.
6) **LAWSUITS AND DISPUTES**: If you are involved in a lawsuit or dispute, we may disclose medical information in response to a court or administrative order. Also in response to a subpoena, discovery request or other lawful process.

You have the following rights regarding medical information that we maintain about you:

1) **RIGHT TO INSPECT AND COPY**: You have the right to inspect and receive a copy of medical records maintained in this facility. You must submit your request in writing and we do charge a small fee for copying and/or mailing out your request. We may deny your request if your account is in our collection process until the account is paid in full.
2) **RIGHT TO AMEND**: If you feel medical information we have about you is wrong, you may ask us to amend the information. Your request must be submitted in writing with the reasons that support your request. We may deny your request if the reasons do not support your request or the information was not created in this office or is not a part of the medical information kept in the clinic.
3) **RIGHT TO ACCOUNTING DISCLOSURES**: This is a list of the disclosures we have made of medical information about you. You must submit your request in writing and must state a time period which may not be longer than 6 years and may not include dates before April 2003. There may be a fee charged if more than one request is made in a 12 month period.
4) **RIGHT TO REQUEST RESTRICTIONS**: You have the right to request a restriction or limitation on the medical information we use or disclose about you. We are not required to agree to your request. You must submit your request in writing with your specific restriction listed.
5) **RIGHT TO CONFIDENTIAL COMMUNICATIONS**: You have the right to request how we communicate with you about medical matters. For example, you can ask that we only contact you at work. Your request must be in writing and must specify how and/or where you wish to be contacted.
6) **RIGHT TO A PAPER COPY OF THIS NOTICE**: You may ask for a copy of this notice at any time.

We reserve the right to change this notice at any time. It will be posted when any changes occur and you may obtain a revised copy at any time. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Other uses and disclosures not covered by this notice or the laws that apply to us will be made only with your written permission. By signing this form, you consent to our use and disclosure of protected information for your treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures as per prior consent.

I, _____ have read and fully understand the statement above concerning privacy of my records at Kokomo Chiropractic, PC.

Dated:_____ Signed: _____
If patient is a minor, parent or guardian must sign statement.