**Grumish Chiropractic HIPAA Patient Privacy Form**

**40 Briarcliff Professional Center Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bourbonnais, IL 60914**

**(815)939-0990 \*\* PRINT CLEARLY \*\***

**Patient Last Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Initial**: \_\_\_\_

**Patient Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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. Grumish 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 Healthcare Information:**

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

**Payment;** We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

**Workers Compensation:** We may disclose your health information as necessary to comply with Illinois Workers’ Compensation laws.

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

**Public Health:** As required by law, we may disclose your health information to public health authorities for 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 coroners or medical examiners.

**Organ Donation:** We may disclose your health information to organization involved in procuring banking or transplant 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 health or safety of a particular person or to the general public.

**Specialized Government Agencies:** We may disclose your health information for military, national security, prisoner and government benefit purposes.

**Marketing**: We may contact you via phone, email or written correspondence for marketing purposes or fund raising purposes.

**Change of Ownership**: In the event that Grumish Chiropractic is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**: You have the right to request restriction on certain uses and disclosures of your health information. Please be advised however, that Grumish Chiropractic is not required to agree to the restriction that you requested. You have the right to have your health information received or communicated through alternative methods or sent to an alternative location other than the usual method of communication or delivery upon your request. You have the right to inspect and copy your health information. You have the right to request that Grumish Chiropractic amend your protected health information in writing. Please be advised, however, that Grumish Chiropractic is not required to amend your protected health information. If your request to amend your health information has been denied you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial. You have a right to receive an accounting of disclosures of your protected health information made by Grumish Chiropractic. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

**Changes to this notice of Privacy Practices:**  Grumish Chiropractic here reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provision effective for all the information that it maintains. Until such amendment is made, Grumish Chiropractic is required by law to comply with this Notice. Grumish Chiropractic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If have questions about any part of this notice, or if you want more information about your pricy rights, please contact Office Manager, Grumish Chiropractic at (815)939-0990. If Grumish Chiropractic is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

**Complaints:** Complains about your privacy rights or how Grumish Chiropractic has handled your health information should be directed to Grumish Chiropractic by calling this office at (815)939-0990 and to make an appointment in person or by telephone within 2 working days. If you are not satisfied with the manner in which the 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 20211.

Notice Effective 9/1/2013. Acknowledged and Agreed Upon by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_

Patient Signature

**This form also acknowledges that patient authorizes the following person(s) to view, records, appointments, billing and other associated private health information and/or request information, or participate in any manner, verbal, written or otherwise communicate with Grumish Chiropractic with regard to my private health information is/are the following until it is changed in writing by me:**

**(If None, clearly note on 1st Line)**

**(CLEARLY PRINT THE NAME AND RELATIONSHIP)**

**NAME(S) RELATIONSHIP**

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Acknowledged and Authorized by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature S:/Libraries/2013 Library of Forms/HIPAA 9 2013