KAISER

CHIROPRACTIC PHYSICAL THERAPY

Emergencies:

If applicable, we may disclose your health care information to your emergency contact.

Public Health:

As required by law, we may disclose your health care information to public health authorities for purposes related to: preventing/controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the FDA problems with products/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 proceedings. This includes anything related to law enforcement, public safety or specialized government agencies.

Marketing and Other Communications:

As a courtesy to our patients we occasionally call your home on the evening prior to your scheduled appointment to remind you of your appointment time. We often leave reminder messages with the person answering or an answering machine/voicemail. No protected health care information will be disclosed during the call other than the date and time of the appointment.

It is our policy to send educational information as well as updates on new services and treatments to our patients through postcards and newsletters. We send these through either email or the post office service.

Change of Ownership:

In the event that Kaiser Chiropractic Offices LLC 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 a right to a copy of this Notice. You have a right to access of all disclosures of your information. You have a right to request an amendment of your information. You have the right to request restrictions to your information. You have the right to inspect and copy your health information.

Complaints:

DHHS, Office of Civil Rights 200 Independence Avenue SW Room 509F HHH Bldg. Washington DC 20201

I have read the Privacy Notice and understand my rights contained in this notice. Below is my signature of authorization and consent to use and disclose my protected health care information.

_____	_____	_____	_____
Patient's Name	Patient's Signature	Facility Signature	Effective Date