

Midlothian Chiropractic Clinic
525 E. Main St., Midlothian, TX 76065
972-723-1155

Provider Notice of Information Practices

Uses and Disclosures of Health Information

We use healthcare information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive.

We may use or disclose identifiable healthcare information about you without your authorization for several other reasons. Subject to certain requirements, we may give out healthcare information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable healthcare information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policy at any time. But before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact our office manager.

Individual Rights

In most cases, you have the right to look at or get a copy of your healthcare information that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed healthcare information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact our office manager. You also may send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and to follow the information practices that are described in this notice.

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By signing this authorization you acknowledge that you have read and agree to our Information Practices Policy. You further agree that you have received a copy for your records.

Acknowledged and agreed to by:

Patient Signature

Date

Address: _____

or, ON BEHALF OF PATIENT

Legal Guardian Signature

Relationship

Date

Patient Name

Address: _____

