



AFFORDABLE CHIROPRACTIC CLINIC

420 East Armour Road
North Kansas City, Missouri 64116
816-889-9800

The purpose of this notice is to detail to our patients how our clinic may utilize and disclose their personal medical information. After reading this notice, you will be asked to sign a consent form. This consent will allow us to use your personal health information for the purpose of treatment, receiving payments, and for the daily operations of our office. It is our policy to release the minimum information to any source not directly linked to the care of our patients as defined by HIPAA (the Health Insurance Portability Accountability Act).

In the case of third party payers, your signed consent form permits us to release information necessary to complete the health insurance claim form.

When a patient wishes to have their protected medical information released, a release form signed by the patient will be necessary before we will release any protected information.

In the case of public health, HIPAA does not protect certain information. When a law enforcement or public health agency requests any information, we will release the minimum information required by the law.

Patients have the right to view their personal medical information.

Our office may use your personal medical information to remind you of appointments, send you birthday cards, mailings, newsletters, and other information about our practice. We will not release mailing lists of our patients to outside parties.

We reserve the right to modify these policies in accordance with legal or practice requirements. We will provide you notice of any such change.

PERSONAL MEDICAL INFORMATION CONSENT FORM

The health Insurance Portability Accountability Act of 1996 (HIPAA) requires that we receive your permission before we use personal information in your medical records for any reason. This consent form gives us permission to use your protected health information to carry out treatment, to receive payment, and as part of the health care operation of our practice. HIPAA also requires us to have a written notice of our privacy policy describing how medical information about you may be used and disclosed. If you so desire, this written notice is available from our staff. HIPAA gives the patient the right to add restrictions to the release of protected health information. You have the right to revoke this consent at any time, though services performed prior to the revocation are covered by this consent.

NAME: _____

DATE: _____

RESTRICTIONS: