

NH Chiros

Dr. Ken George & Associates, P.A.

PATIENT PRIVACY RIGHTS

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED,
AND HOW YOU CAN ACCESS THIS INFORMATION.**

OUR LEGAL DUTY:

Dr. Ken George and Associates, P.A. (NH Chiros) is required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. Dr. Ken George and Associates, P.A. (NH Chiros) must follow the practices that are described in this Notice while it is in effect. This Notice takes effect today, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this privacy Notice at any time, provided such changes are permitted by applicable law. Before we make the significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: we may use or disclose your health information to a physician or other healthcare professional providing treatment to you. Also, if any diagnostic services are required, your information may be used to identify your case. We may use and disclose your health information to obtain payment for services we provide to you through your insurance carrier.

You may also give Dr. Ken George and Associates, P.A. (NH Chiros) written authorization to use your health information or to disclose it to anyone for any purpose. If you give us such authorization, you may revoke it in writing. We will not disclose your health information for any reason except those described in the Notice. We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or if there is an emergency. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information. We will not allow the use of your health information for any marketing communications without your permission. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. Dr. Ken George and Associates, P.A. (NH Chiros) may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS:

You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. We may charge a reasonable cost-based fee for expenses such as copies and staff time. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations. You have the right to request that we amend your health information. Again, your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

If you want more information about our privacy practices, or have any questions or concerns, please contact us.

By signing below, I acknowledge and understand my patient privacy rights as disclosed above:

Patient or Parent/Guardian Signature: _____ Date: _____