HIPAA NOTICE OF PRIVACY PRACTICES AND PATIENT AUTHORIZATION

Infinity Chiropractic and Sports Rehabilitation

Dr. Kimberly Anne Miller, DC

All staff of Infinity Chiropractic and Sports Rehabilitation

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.

We are 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.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example: Treatment: We may disclose your information to another healthcare provider involved in your care. Payment: We may use your information to obtain payment for services. Healthcare Operations: We may use it for quality review and staff training.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to inspect, copy, amend, and restrict access to your medical records, as well as receive confidential communications. You may request a paper copy of this notice at any time.

OPTIONAL: AUTHORIZATION TO DISCUSS CARE I authorize Infinity Chiropractic and Sports Rehabilitation to discuss my care with:

Name: _____ Relationship: _____

OPTIONAL: CONSENT FOR COMMUNICATION I consent to receive appointment reminders or relevant health updates via: ( )Email ( )Text Message ( ) Voicemail

OPTIONAL: VIDEO & PHOTO RELEASE I authorize Infinity Chiropractic and Sports Rehabilitation and Dr. Kimberly Anne Miller, DC, to photograph or record video of me for the purpose of documenting clinical treatment, educational use, and/or promotional purposes (e.g., website, social media, internal presentations). ( ) I consent ( ) I do not consent

ACKNOWLEDGMENT OF RECEIPT I acknowledge that I have received and reviewed this HIPAA Notice of Privacy Practices and understand my rights. I may revoke this authorization at any time in writing.

Patient Name (Print): _____

Signature: _____ Date: _____

This form complies with HIPAA and Georgia state privacy laws. Please keep a copy for your records.