ANDOVER
SPINE & HEALTH
A Chiropractic Wellness Center

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

105 S. Andover Road, Suite E, Andover, KS 67002
(316)733-9555 www.andoverspine.com

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HIPAA NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT FORM

By signing this form, you will consent to our office using and disclosing your protected health information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have to right to have a copy of and to read our Notice of Privacy Practices prior to signing this form. It describes treatment, payment and healthcare operations and the use of your information. We reserve the right to change our Privacy Practices. A revision notice will be provided upon change. A copy of our Private Practice may be obtained at any time by asking the front desk staff.

You have the right to revoke this Consent at any time by giving written notice to our office. Please note that we may decline to treat you if you decline this Consent.

I have read and understand the content of the privacy consent form. I give my consent for this office to use and disclose my personal health information for treatment, payment activities and health care operations.

Patient's Name: _____

Patient's Signature: _____ Date: _____

(tap here to sign electronically by clicking add signature)

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