



NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Uses and Disclosures

In the course of your care at DuPuy Family Chiropractic, we may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes:

- ❖ **Treatment**: *Example*: We may use our health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.
- ❖ **Payment**: *Example*: We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.
- ❖ **Health Care Operations**: *Example*: We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.
- ❖ **Personal Communications Unique to DuPuy Family Chiropractic**: *Examples*: In order to make your experience with our office more efficient, productive, and to further enhance you access to quality health care, we may use your health or personal information for the following purposes:
 - Others may be able to view your name on our daily sign-in sheet.
 - We may use your personal information in order to send you birthday cards.
 - Others may be able to view your name on our “New Patient” board.
 - This office performs Reports in a group setting.
 - This office performs healing adjustments in an “Open Adjusting” environment.
 - This office may use your personal information to contact you regarding appointments (future and missed), workshops, meetings, products, and other Chiropractic Care related issues. If you are not at home, work, or unreachable on your cell phone, a message may be left on your answering machine, voice mail, or with another person in your household.
 - Your personal and health information may be disclosed to others in patient testimonials provided by you.
 - We may also contact you via e-mail regarding scheduling and may send you occasional educational material via e-mail.

We may use or disclose your protected health information without your written consent, written authorization, or oral agreement under the following circumstances:

- ❖ If we provide services to you while you are an inmate.
- ❖ If we provide services to you in an emergency situation.

- ❖ If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.
- ❖ If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.
- ❖ If we need to notify, or assist in the notification of , a family member, personal representative or another person responsible for your care of your location, general condition, or death.
- ❖ If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.
- ❖ If we are required to disclose your health information to the Food and Drug Administration.
- ❖ If we are required to disclose your health information to your employer to evaluate whether or not you have a work related injury or illness.
- ❖ If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.
- ❖ If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
- ❖ If we are required to disclose your health information in response to a court order or a subpoena.
- ❖ If we are required to disclose your health information to a law enforcement official.
- ❖ If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- ❖ For research purposes.
- ❖ If we, in good faith, believe that the use or disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- ❖ If we are authorized by law to disclose your health information to comply with laws established to provide benefits for work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OR DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION.

Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/or disclosure of your health information must be made in writing to our Privacy Official.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to our Privacy Official. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right To Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right To Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be

made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right To Receive an Accounting. You have the right to receive an accounting of our disclosures of health information made six years prior to the date of your request. We will provide you with the first accounting in any 12-month period at no charge. There will be a fee charged for any subsequent requests. Your request to receive an accounting must be made in writing to our Privacy Official. The accounting will not include the following disclosures:

- ❖ Disclosures made to carry out treatment, payment and health care operations.
- ❖ Disclosures made to you.
- ❖ Disclosures made in our facility directory.
- ❖ Disclosures made to individuals involved in your care.
- ❖ Disclosures made for national security or intelligence purposes.
- ❖ Disclosures made to correctional institutions or law enforcement officials.
- ❖ Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of this notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in terms of this notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request.

Complaints

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by writing to our Privacy Official at the address that follows, or you may place your written complaint in the suggestion box located in the front waiting area. We will not take any action against you for filing a complaint.

DuPuy Family Chiropractic
ATTN: Mrs. Stephanie Hallam
1209 NE Main Street
Simpsonville, SC 29681

How to Contact Us

If you would like further information about our privacy practices, please contact:

Dupuy Family Chiropractic
ATTN: Mrs. Stephanie Hallam
1209 NE Main Street
Simpsonville, SC 29681

All requests to revoke previously stated Disclosures must be made in writing. The following attached form may be used to revoke said Disclosures. Multiple forms are available upon request.

This notice is effective as of September 14, 2009. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created.



Request for Revocation of the Authorization for the Use and Disclosure of Protected Health Information

This revocation has been requested by: _____

The information to be revoked: _____

The reason for revocation (if any):

Patient's Printed Name

Patient's Signature

Date

Witness Printed Name

Title

Witness Signature

Date

Approved By Printed Name

Title

Approved By Signature

Date



I, _____, acknowledge that I have received a full printed
Printed Full Name

copy of THE NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION
from DuPuy Family Chiropractic.

Signature Date: _____

Witness Date: _____