Dr. Julie Niedwick • 2106 Aspen Drive*Mechanicsburg, PA 17055

Patient Privacy Policy Notice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care, a basis for planning my care and treatment, a means of communication among the many health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, a means by which a third-party payer can verify that services billed were actually provided, and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
2. Inadvertent disclosures- We have a semi-open treatment area that means open discussion. If you need to speak privately to the doctor please let our staff know so we can make arrangements for a private consultation. Your name may be mentioned in front of other patient's unless you specifically request us not to do so.
3. For payment purposes - to obtain payment from your insurance company or other source such as a bank or credit card company.
4. For workers compensation or personal injury purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons -discussion with coroners and medical examiners in the event of a patient's death
10. Telephone calls, text messages or emails and appointment reminders-We may call your home and leave messages regarding a missed appointment or inform you of changes in practice hours or upcoming events. Greeting cards, letters, appointment and hours notices may be mailed or emailed to you.
11. Change of ownership in the event the practice was ever sold the new owners would have access to your personal health information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of a more comprehensive privacy notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and can be signed out at your request but must be returned to our office.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please contact our office directly and ask to speak with Vanessa Rinearson, Office Manager (717) 766-9700 or email us at madeirachiropractic@gmail.com or in writing at 2106 Aspen Drive Mechanicsburg, PA 17055. If you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

I have read and reviewed this Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Patient Privacy Policy" at a time in the future and will make the new provisions effective for all information that it maintains past and present.
I am aware that a copy of this "Notice" is available by request at the front reception desk. At this time I do not have any questions regarding my rights or any of the information I have received and I understand that I have the right to request certain restrictions to the use or disclosure of my health information and agree to notify, Madeira Chiropractic in writing if I desire to do so.

Patient Name_____ Signature _____ Date _____
(patient / parent / guardian)