

Zimmermann Chiropractic & Wellness Center

Confidentiality Notice

General Information:

Information about your treatment and care, including payment for care, is protected by two federal laws: The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)* and the Confidentiality Law**. Under these laws this practice may not say to a person outside of the practice that you are a patient belonging to this practice or any other information that may tie you to the practice.

This practice may obtain written consent before it can disclose information about you for payment purposes. For example, the practice must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before this practice can share information for treatment purposes or for other health care operations. However, federal law permits the practice to disclose information in the following circumstances without written permissions:

1. To practice staff for the purpose of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal Government);
4. To report a crime committed on the practice's premises or against program personnel;
5. To medical personnel in a medical emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before this practice can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

*42 U.S.C 130d et.seq., 45CFR Parts 160 and 164

** 42 U.S.C 290dd-2, 42 C.F.R Part 2

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The practice will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained in the practice.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the practices records, and to request and receive an accounting of disclosures of you health related information made by the practice during 7 year prior to the request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.
- To make any of the above requests, you must fill out the appropriate form that will be provided by the practice.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information in the Practice

In order to provide you with the best care, the practice will use your health and treatment information in the following ways:

- Communication among practice staff (including students or interns) for the purposes of treatment needs, treatment planning, process reporting and review, staff supervision, incident reporting, billing operations, medical record maintenance, and any other related treatment processes.
- Communication with Business Associates such as clinical laboratories (blood work, urinalysis, imaging services or long term record storage).
- Reporting data to the NYS OASAS Client data system

IF YOU WOULD LIKE A COPY FOR YOUR RECORD PLEASE LET RECEPTION KNOW.

-THANKYOU-

The Practice's Duties

The practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The practice is required by law to abide by the terms of this notice. The practice reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The practice will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

I, _____ have received a copy of the Confidentiality Notice, and it has been explained to me.

_____ Signature _____ Date

_____ Parent/guardian signature _____ Date