<u>NOTICE OF PRIVACY PRACTICES SUMMARY</u>

Due to implementation of Federal guidelines known as HIPAA, we must inform you of what we do in order to keep your protected health care information private. Furthermore, we are required to have your signature to verbally discuss any protected health information with persons not directly involved in your healthcare (i.e. family members, caregivers, etc.)

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided for your review.

Market Place Chiropractic Wellness Center, PLLC, uses health information about you for treatment, to obtain payment for treatment with your authorization as required, for administrative purposes, and to evaluate the quality of care that your receive.

Market Place Chiropractic Wellness Center, PLLC, will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Market Place Chiropractic Wellness Center, PLLC, may also use your information to provide appointment reminders, information about treatment alternatives and other health-related issues.

Market Place Chiropractic Wellness Center, PLLC, may disclose your information for public health activities and governmental function in order to comply with worker's compensation laws and regulations. You have a right to request restriction, request and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may file a complaint with the privacy officer Dr. Jeffrey P. Clark and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Market Place Chiropractic Wellness Center, PLLC, must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints please contact Dr. Jeffrey P. Clark at (425)335-0300.

<u>Authorization of Verbal Disclosure of Protected Health Information</u>

I hereby give my authorization for verbal disclosure of my protected health information to be disclosed to:

Name of Person ______________________________ **Date of Birth** ______________

Relationship ______________________________ **Phone Number(s)** ______________

Name of Person ______________________________ **Date of Birth** ______________

Relationship ______________________________ **Phone Number(s)** ______________

Name of Person ______________________________ **Date of Birth** ______________

Relationship ______________________________ **Phone Number(s)** ______________

Please check which place(s) we can leave a detailed message for you and provide telephone numbers:

☐**Home:**______________ ☐**Cell:**______________ ☐**Work:**______________

______________________________ ______________________________

Patient Signature **Date**

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Print Name ****Note: Any changes must be made in writing**