

**Katz Chiropractic & Rehabilitation Clinic**

**Front Range Digital Motion X-Ray**

954 North Street, Second Floor, Boulder, CO 80304

Phone: 303-938-9070 ~ Fax: 303-938-9170

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***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.***

**DISCLOSURE OF INFORMATION**

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Workers' Compensation and Public Health Laws as well as judicial proceedings. We may contact a family member or other authorized person in consent unless compelled to do so by legal authority. Further, you will be contacted by phone or mail in the event that a request for information is made.

**FACILITY SET UP**

While our examination and treatment rooms are private, this office utilizes an open exercise/rehabilitation setting. Staff and doctors will maintain policies to ensure privacy, but there may be some inadvertent disclosures to others in the facility at the same time. If there is private information that you need to discuss, please request to do so in a private room.

**YOUR RIGHTS**

You may send us a written request to see or procure a copy of the information that we have about you, or to amend you personal information that you believe is incomplete or inaccurate. If the information was not originally from our office, we will refer you to the source, such as other doctors or hospitals.

You may request additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances, may be prohibited by law.

You may request that we communicate with you about medical matters using reasonable alternative means or at an alternate address.

You may receive an accounting of our disclosures of your medical information, except when those disclosures are made for treatment, payment or health care operations, or the law otherwise restricts the accounting.

You have the right to inspect and have a copy of your medical information. There is no cost for the first copy and any copy thereafter will be \$25.

You have the right to amend your information. Please note that we have the right to disagree with your amendments. If there is a disagreement, you will be provided with information about your denial of your amendment and how you may appeal the denial of amendment. You have a right to a copy of the notice upon request.

**COMPLAINTS**

Calling this office or directing a letter to the office manager can handle complaints about your privacy rights or how your privacy is handled at this office. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to: DHHS (Office of Civil Rights) 200 Independence Ave Room 509F HHH Building Washington, D.C. 20201

I have read this privacy Notice and understand my rights contained in this notice. By signing this form I provide authorization and consent to use and disclose my protected health information as noted above.

\_\_\_\_\_  
Patient's Name (Print)

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date