Dr. Kristina Nielsen

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Notice of Privacy Practice Summary & Consent to Use and Disclose of Health Information

This summary discloses how health information about you may be used. By signing this form, you are granting consent to Downtown Chiropractic to use and disclose your protected information as described below.

Downtown Chiropractic 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 you receive.

Downtown Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requests us to do so.

Downtown Chiropractic may use your information to provide appointment reminders, information about treatment alternatives, or other health related issues.

Downtown Chiropractic may disclose your information for public health activities, research, health and safety, and/or governmental function in order to comply with workers compensation laws and regulations.

Downtown Chiropractic must maintain the privacy of protected health information, to provide you with notice of its legal duties and privacy practices with respect to your health information, and to abide by the terms of the notice. You have the right to request that we restrict how we use and disclose your protected health information we may not be required by law to grant your request, and if unable to accommodate, we will notify you. We will attempt to accommodate reasonable requests you make to communicate your 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 as permitted under law. You also have the right to a report and to retain a copy of your health record, and to request communication of your information by alternative means at alternative locations, and to revoke your authorization and request communication of your information by alternative means at alternative locations, and to revoke your authorization and request an accounting of your health records.

If you have any questions please call (509) 844-2226.

Patient Signature _____ Date _____