HIPPA PRIVACY POLICY

Tierrasanta Chiropractic Group
10444 Clairemont Mesa Blvd.
San Diego CA 92124

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.

Any information given to this office either verbally or in writing is kept in the strictest confidence. You have a right to receive any of your patient information at any time. Just request the information. We will have you sign for it and copies will be made available to you. We will not release any of this information to any third party without written consent from you.

By signing this form, you are hereby authorizing us to release your information to your insurance company and/or your attorney in order to receive payment for services, to carry out treatment or other healthcare operations.

If we need to contact you via telephone/email/fax/mail we will not leave any personal information. We will only leave your appointment date and time and/or a request for you to contact us.

All other uses of your protected health information will only be made with your authorization and you have the right to revoke such authorization at any time.

In the case that you are a minor your parents have access to your health information.

By signing this form, you are authorizing us to communicate with any other health care provider with whom you are co-treating. We will use the "minimum necessary" rule and only release information that would be beneficial/detrimental to your health.

We are required to keep your records for seven years past your last visit date.

PATIENTS RIGHTS

- You may request restrictions on certain uses and disclosures of protected information.
- You have the right to receive confidential communication of protected health information.
- You have the right to inspect and copy protected health information.
- You have the right to amend protected information.
- You have the right to an accounting of protected information.

We reserve the right to change our privacy policy at any time. At the time of your next visit after any changes you will be notified in writing.

Patient's Name: _____

Patient's Signature: _____ Date: _____