THIS NOTICE IS PRESENTED IN COMPLIANCE WITH FEDERAL HIPAA REQUIREMENTS FOR HEALTH CARE PROVIDERS AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY
HIPAA PRIVACY COMPLIANCE POLICY EFFECTIVE 04/01/03

**HETRICK CHIROPRACTIC**
**DR. MAURA L. TIMM, D.C.**
**560 SOUTH ESCONDIDO BLVD.**
**ESCONDIDO, CA 92025**
**760-741-0774**

Question: What is this HIPAA compliance form all about?

Answer:

Basically, all this says is that we will act to keep your health related information private except that you allow us to release pertinent information to: (1) your insurance company or other 3rd party payers, so they can pay your bill; (2) your other doctors, for information you want them to have from us; (3) your attorney or anyone else you request and authorize us to release it to; (4) our business partners.

Examples:

1. Outside billing companies, outside marketing companies that might produce and mail our newsletters, etc. If we use any such company, they too will maintain the same level of privacy we maintain.
2. Your legal representative(s) should you for any reason become unable to speak and or act for yourself in making health care related decisions.
3. Your providers of emergency treatment as consistent with our awareness of your needs and the doctor's best judgment, i.e. you are in the emergency room and they need medical information about you from us.
4. Your family, friends or others that may answer your phone, read your mail, or otherwise communicate with us as part of our exchanging information with one another that is necessary to your care and relationship with this office, i.e. we can call your home and leave a message for you on your answering machine or with any person that answers; we can send you a fax or e-mail that might be read by any other person with access to your fax or e-mail; we can leave a message for you at work on any recording device or with any person limited to our name, phone number, and the level of necessity/urgency that you contact us.

WE MUST OBEY THE LAW

You should be aware that government agencies can abridge your right to privacy and legally require us to release information even against your will; i.e. in cases of child abuse where the parent does not authorize the release of this information; in instances where you might be a threat to yourself or others i.e. suicidal. The office will obey the law in respect to any current or future requirements to report or release information

APPOINTMENT REMINDER, BIRTHDAY CARDS AND NEWSLETTER

The Practice may contact you to provide appointment reminders, information on treatment alternatives or other health related information, offers, benefits and services that may be of interest to you. The following communications are used by the practice: postcards mailed to you at the address provided by you; telephoning your home and leaving a message on your answering machine or with the individual answering the phone; we will remember you on your birthday with a customary card; newsletters, with health information we believe to be valuable to you, will be sent periodically.

FACSIMILE, E-MAIL& OTHER ELECTRONIC TRANSMISSIONS

The Practice may transmit information about you to insurers, other health care professionals and providers, and appropriate governmental agencies utilizing facsimile transmissions, e-mail and other electronic means.

YOU CAN REVIEW, RESTRICT AND OR REVOKE ACCESS TO YOUR INFORMATION

Space is provided below on this form for you to list any objections, restrictions, limitations, etc. that you want to apply to your information in our office. This can include the names of individuals that are to have no or limited access to your information and if limited, the parameters of that limitation; i.e. the name of your 14 year old child where you allow that we can leave messages for you but not discuss the details of your health. You can update this information at any time, in person or over the phone, i.e. you still live with a significant other but you no longer want us to leave any messages with them.

AGREEMENT AND SIGNATURE DATED _____/_____/_____.

By signing below I acknowledge that I understand and agree to the above and have indicated any restrictions I wish to apply to my records below.

Patients Name:_____Signature of Patient:_____

Parent/Guardian Name:_____Signature of Parent/Gardian_____

MY PRIVACY RESTRICTIONS: PRINT NAME:_____SIGNATURE_____

DATE:_____

As of this day I wish the following restrictions to apply to the disclosure of my private health information in the office of Dr. Maura L. Timm, D.C.:

1.

2.