

HIPPA NOTICE OF PRIVACY PRACTICE

WASATCH SPINAL CARE
8915 South 700 East, Suite 101
SANDY, UT 84070
801-508-2996

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.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you. Including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a health agency that provides care for you. Your protected health information may be provided to a physician or facility to who you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment

Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for treatments may require that your relevant protected health information be disclosed to the health plan to obtain approval for chiropractic benefits

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of Utah Family Spinal Care. These activities include, but are not limited to, quality assessment activities, employee review activities, training of staff, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law. Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Research: Criminal activity: Military Activity and National Security Workers Compensation: Required uses and Disclosures Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500

Other Permitted and Required Uses and Disclosures will be made only with your consent authorization or opportunity to object unless required by law.

You may revoke the authorization at any time in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information

Under federal law, however, you may not inspect or copy the following records: Information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.

Which means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, ie, electronically.

You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to obtain or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact, of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before January 1, 2020

A COPY WILL BE PROVIDED UPON REQUEST

Wasatch Spinal Care
8915 South 700 East, Suite 101
Sandy UT. 84070
Phone: 801-508-2996
Fax: 801-508-2981

RECEIPT OF NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I ACKNOWLEDGE THAT I RECEIVED THE PRACTICE'S NOTICE OF PRIVACY PRACTICE.

I _____ give my permission to Wasatch Spinal Care
to speak to _____ (name of person)

Relationship to me _____

Regarding my health condition and treatment plans.

Additional people who may receive my health information:

_____ relationship _____

_____ relationship _____

_____ relationship _____

I have received the HIPAA notification from Wasatch Spinal Care and accept the terms written therein.

Signature _____ Date: / /

Patient Name _____

Relationship to Patient _____ ☐ ✓ if signing for minor