HIPAA NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this document is designed to tell you how we may, under federal law, use or disclose your Health Information.

Effective Date of this Notice: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTIVE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal law and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Brandon Crawford – HIPAA Compliance/Privacy Officer
(512) 258-8880

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMAITON (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We may take x-rays in order to better serve you. Many of the people who work for our practice – including, but not limited to, our doctors, assistants and technicians – in our office may access your information for purposes of providing your care.

2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example our billing office may access your information – and send relevant parts to your insurance company to allow us to be paid for services we render to you. Also, we may use your IIHI to bill you directly for service and items.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may need to use your IIHI to evaluate the quality of care you received from us; send information to our attorneys or accountants; or to conduct cost-management and business planning activities for our practice.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

5. **Change of Ownership.** Our practice may use and disclose your IIHI in the event that our practice is sold or merged with another organization, and your Health Information/record may then become the property of the new owner.

D. WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION IN CERTAIN CIRCUMSTANCES WITHOUT OBTAINING YOUR PRIOR CONSENT OR AUTHORIZATION

1. **To Provide It To You.**

2. **To Notify And /Or Communicate With Your Family.** Unless you tell us you object, we may use or disclose your Health Information in order to notify your family or assist in notifying your family, your personal representative or another person responsible for your care, about your location, your general condition or in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in any communications with your family and others.

E. USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your individually identifiable health information:

1. **Public Health Purposes.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Preventing or controlling disease, injury or disability
   - Reporting child abuse or neglect
   - Reporting domestic violence
   - Reporting to the Food and Drug Administration reactions to drugs or problems with products or devices
   - Reporting disease or infection exposure

2. **Health Oversight Activities.** Our practice may disclose your IIHI to health oversight agencies for activities authorized by law: during the course of audits, investigations, inspections, licensure and other proceedings.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to subpoenas or for judicial and administrative proceedings. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person.

4. **Law Enforcement.** Our practice may release IIHI if asked to do so by a law enforcement official:

   - To identify/locate a suspect, material witness, fugitive or missing person
   - In response to a warrant, summons, court order, subpoena or similar legal process

5. **Deceased Patients.** Our practice may release IHII to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. **Organ and Tissue Donation.** Our practice may release your IHII to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. **Research.** Our practice may release your IHII in order to conduct research that has been approved by our Institutional Review Board.

8. **Public Safety.** Our practice may release your IHII when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the general public.

9. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs, which are necessary to comply with worker's compensation laws.

11. Inmates. Our practice may disclose your IHII to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.

F. FOR ALL OTHER CIRCUMSTANCES, WE MAY ONLY USE OR DISCLOSE YOUR HEALTH INFORMATION AFTER YOU HAVE SIGNED AN AUTHORIZATION. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

G. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate **reasonable** requests. In order to request a confidential communication, you must make a written request to **Brandon Crawford– the practice's HIPAA Compliance/Privacy Officer; for more information he can be reached at (512) 258-8880. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. **We are not required to agree to your request.**

Inspection and Copies. You have the right to inspect and obtain a copy of your Health Information. You must submit your request in writing to **Motion Chiropractic**. Our practice may by law charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

2. **Amendment.** You have the right to ask us to amend your Health Information if you believe the information is incorrect or incomplete. We are not required to change your health information. However, we will provide you with information about our denial and how you can disagree with said denial.

3. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures" of their Health Information made by us, **except** that we do not have to account for disclosures:

- Authorized by patients
- Made for treatment, payment, or health care operations
- Information provided to patients
- Notification and communication with family
- Certain government functions
- Appointment reminders

4. Right to a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact **the staff of Motion Chiropractic.**

H. **Our Duties.** We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all of your Health Information – even if it was created prior to the change in the Notice. If such amendment is made, we will immediately display the revised Notice at our office and provide you with a copy of the amended Notice. We will also provide you with a copy, at any time, upon request.

I. **Complaints to the Government.** You my make complaints to the Secretary of the Department of Health and Human Services (DHHS), if you believe your rights have been violated. We promise not to retaliate against you for any complaint you make to the government about our privacy practices.

J. Contact Information. You may contact us about our privacy practices by calling the Practice's Privacy Officer –Brandon Crawford (512)258-8880; Or you may contact The US Department of Health & Human Service at:

200 Independence Avenue – SW
Washington, DC 20201
Telephone: 1-877-696-6777

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize ***Dr. Brandon Crawford, D.C.*** ("Covered Entity" the "Practice") to release my health information described below to:

Recipient Name:

Recipient Address:

Recipient Telephone Number:

Documents/Information to Be Released:

Purpose of Disclosure (explain or indicate "at the request of the individual"):

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this authorization, at any time prior to Covered Entity's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in Covered Entity's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization and my signature and that I should send it to:

Dr. Brandon Crawford
8701 W. Parmer Ln. Ste #2121
Austin, Tx 78729
Phone: (512)258-8880

Attention: Privacy Officer – Brandon Crawford, DC

I understand that I am not required to sign this authorization and that Covered Entity may not condition treatment on my execution of this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon Covered Entity's release of the information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

I hereby acknowledge receipt of a copy of this Authorization.

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Signature of Individual or Personal Representative

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Description of Personal Representative's Authority

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Date of Authorization