

## Notice of Privacy Policy for Patient's Protected Health Information

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.**

THE PATIENT IDENTIFIED ABOVE AUTHORIZES **MOLIVER CHIROPRACTIC, PLLC** TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

### SPECIFIC AUTHORIZATIONS

- I give permission to **Moliver Chiropractic, PLLC** to use my address, phone number, email address and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.
- If **Moliver Chiropractic, PLLC** contacts me by phone, I give them permission to leave a phone message with a member of my household, on my answering machine, or voice mail.
- I give **Moliver Chiropractic, PLLC** permission to treat me in an area where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, the doctor will provide a room for these conversations.
- I give **Moliver Chiropractic, PLLC** permission to display my entire, unedited testimonial or an unedited excerpt written on their behalf in their Our Patients Speak Book or in print ad material.
- By signing this form you are giving **Moliver Chiropractic, PLLC** permission to use and disclose your protected health information in accordance with the directives listed above.
- Moliver Chiropractic, PLLC** has their Notice of Privacy posted for review. **You have the right to inspect or copy the Notice of Privacy and/or Moliver Chiropractic Privacy Policy.**

**Seth L. Moliver, DC**

624 Jetton Street, Suite 260 | Davidson, NC 28036 | Phone 704.896.3435 | Fax 704.896.3424  
drseth@moliverchiro.com | www.moliverchiro.com

## YOUR RIGHTS

### **Get an electronic or paper copy of your medical record**

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct your medical record**

You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

### **Ask us to limit what we use or share**

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

**ONLY** if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say “yes” unless a law requires us to share that information.

### **Get a list of those with whom we’ve shared information**

You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Choose someone to act for you**

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

### **File a complaint if you feel your rights are violated**

You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). We will not retaliate against you for filing a complaint.

## YOUR CHOICES

### **For certain health information, you can tell us your choices about what we share.**

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information

**In the case of fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you again.

## **OUR USES AND DISCLOSURES**

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

- **Treat you**

We can use your health information and share it with other professionals who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

- **Run our organization**

We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We use health information about you to manage your treatment and services.*

- **Bill for your services**

We can use and share your health information to bill and get payment from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

### **Help with public health and safety issues**

We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.

### **Do research**

We can use or share your information for health research.

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests**

We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

**Changes to the Terms of This Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

*Effective September 23, 2013*

Your healing experience is one of trust between you and us. Speak to our privacy officer, Dr. Seth Moliver, at 704-896-3435 regarding privacy issues. We hold your health and your health concerns in the highest regard. Your personal privacy will never be violated.

\*\*\* A COPY OF THE SIGNED AUTHORIZATION WILL BE PROVIDED TO YOU IF REQUESTED \*\*\*

Patient Name (print clearly) \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Personal Representative \_\_\_\_\_

Description of Representative's Authority to Act for Patient:

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