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.

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 display my entire, unedited testimonial or an unedited excerpt written on their behalf in their Our Patients Speak Book or in print ad material.

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.**

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 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

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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