Notice of Privacy Practices and Consent Form

This office does ***not*** transmit protected patient information via the internet. We believe this to be the very best way to protect your Personal Information. Patient records are created and maintained in paper format only. Accounting records are kept in a database ***NOT*** connected to the internet and we are strictly a paper claim filer. Our small office is classified as and maintains a status of NON-COVERED Entity as described in the Health Information Portability and Accountability Act and is therefore exempt from the requirements of Covered Entities. The following information and consent is provided as a courtesy rather than a mandate.

As our patient, we want you to know that we respect the privacy of your personal chiropractic records and will do all we can to secure and protect that privacy through reasonable precautions. All information contained in your record is confidential and will not be disclosed without your written consent. In certain circumstances, we may have indirect treatment relationships with you (such as laboratories that only interact with physicians, not patients), and may have to disclose personal health information for purposes of treatment, payment, or as required by government agencies. These entities are most often not required to obtain patient consent. When it is appropriate and necessary, we provide the minimum information to only those we feel are in need of this information, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal chiropractic records and will provide copies (including radiographs), upon your written request, at no charge. Should a non-physician third party request records on your behalf, a reasonable fee will be charged to the requesting party for the service.

If you choose to give consent in this document, at some future time you may request to refuse all or part of your permission to disclose. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You may request, at any time, a copy of this notice for your records.

I agree to allow representatives of Chiropractic Caring For You, LLC to disclose by phone my Personal Health Information, including date/time of appointments to:

☐Spouse _____ ☐Other (family, friend, etc) _____

(print name) (print name)

☐Myself only, no other persons

THIS DOES NOT SERVE AS AN AUTHORIZATION TO RELEASE MEDICAL RECORDS

☐**Please check if office staff may leave voice messages at the telephone number(s) you have provided**

I have reviewed and understand this Notice of Privacy Practices for:

_____

print name of patient/Legal Representative

_____ _____

signature of patient/legal representative date of birth

Chiropractic Caring For You, LLC
2151 N. Main Street
Las Cruces, NM 88001
575 524-0400