Gelardi
Chiropractic
creating the opportunity for your body to heal itself

Notice of Privacy Practices (HIPAA)

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.

OPTIONAL:

_____ I wish to file a "Request for Alternative Communications" of my protected health information. *(such as "please allow [name], my spouse, to see my records at any time")* Write your request below.

_____

_____

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_____

I understand this office is not required to honor any requested changes to the "Notice of Privacy Practices."

I have read the full Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide this practice with my authorizations and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice. (If I would like a copy of the full HIPAA Privacy Statement, one will be provided to me).

Signature _____ *date* _____

Print name _____

OFFICE USE: *Authorized Facility Signature* _____

This notice is effective as of July 1, 2009.