GLASGOW CHIROPRACTIC

2505 Pocoshock Place, Suite 101
Richmond, VA 23235
info@glasgowchiropracticpllc.com
Phone: (804) 745-1605
Fax: (804) 745-1802

NOTICE OF PRIVACY PRACTICES

Glasgow Chiropractic respects your privacy and is committed to protecting your information. We are required by law to maintain the privacy of your protected health information, provide you with a notice of our legal duties and privacy practices with respect to protected health information, and notify you following a breach of unsecured 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.**

Your protected health information (PHI) consists of any identifying information related to your medical record. Your PHI is shared with office staff in order to run our practice, with other healthcare providers who are involved with your care, and as required by federal and state law. **We will never share your PHI with anyone else without your authorization.**

You have the right to authorize us to share your PHI with anyone of your choosing; to do so, please complete our PHI Release Authorization form. You may also authorize us to share your PHI by a message through our Patient Portal or by giving verbal permission. You can revoke previous authorizations by mail, verbal communication, or a message through our Patient Portal. If you grant someone medical power of attorney, that person may act on your behalf regarding your PHI, as can your legal guardian. We will verify his or her authority before taking action. You also have the right to ask us to contact you in a specific way (e.g., an alternative phone number). We will agree to all reasonable requests. If in any event you are unable to tell us your preference, we may share your PHI as we deem fit.
You have the right to request restrictions on how we use and disclose your PHI, although we are not required to comply if the use in question is provided for by law.

Upon request, we will provide you with a copy or summary of your medical record or health information within 30 days and for a reasonable, cost-based fee.
Upon request, we will provide you with an accounting of previous disclosures of your PHI, excepting disclosures that were for the purpose of treatment or practice operations.
Upon request, we will consider making corrections to your medical record or health information, and will explain our decision to you in writing within 30 days.
Upon request, we will promptly provide you with a paper copy of this privacy notice.

If you feel your rights have been violated, please let us know by completing our complaint form so that we may rectify the situation. Our complaint form is available upon request. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. We will not retaliate against you in any way for filing a complaint.

We are required to abide by the terms of this notice, which is effective as of 12/9/2016. We may 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 website. For further information regarding our privacy practices, please contact Robert Glasgow, D.C., at (804) 745-1605.

By signing below, you acknowledge that you have received and read this notice of our privacy practices.

Printed name of patient	Printed name of legal guardian (if patient is under 18)

Signature of patient (or legal guardian, if patient is under 18)	Date	Relationship to patient (if not self)

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PHI RELEASE AUTHORIZATION

I authorize Glasgow Chiropractic to release my protected health information (PHI) per the terms of this document. **I understand that Glasgow Chiropractic cannot discuss my PHI with ANYONE without my explicit authorization**, except as is permitted by law, such as for the purposes of treatment.

Persons authorized to receive PHI: ____________________

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PHI to be released: *(If you wish for your full record to be eligible for release, please write "full record")*

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Reason for release: *(If there is no specific reason, please write "for discussion purposes"; we will then discuss your PHI with those listed above as we deem fit and reasonable)* ____________________

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This PHI Release Authorization will be valid for one year from today's date unless revoked or I specify an earlier expiration date here: ___________

I understand that I have the right to revoke previous PHI Release Authorizations and that Glasgow Chiropractic will immediately honor all requests made by verbal communication with office staff, certified mail sent to the practice address, and secure messages sent through the Patient Portal. Any revocation of a PHI Release Authorization will not apply to any previously completed and approved disclosure.

I understand that once my PHI is disclosed pursuant to this Authorization, federal law privacy protection may no longer apply to the disclosed PHI, and thus the recipient could re-disclose that PHI.

I understand that signing this form is purely voluntary and that Glasgow Chiropractic may not condition treatment or payment on my signing of this Authorization.

By signing below, I give Glasgow Chiropractic permission to release my PHI as detailed above.

____________________	____________________
Printed name of patient	Printed name of legal guardian (if patient is under 18)

____________________	__________	____________________
Signature of patient (or legal guardian, if patient is under 18)	Date	Relationship to patient (if not self)