DZIURA CHIROPRACTIC CENTER

PRIVACY STATEMENT ACKNOWLEDGEMENT

At Dziura Chiropractic Center maintaining our patients trust and confidence is very important to us. That is why we have made it our priority to keep the information you provide us safe and confidential. Our employees are educated on the importance of maintaining the confidentiality of your health information.

The Practice's Privacy Notice has been provided to me prior to my signing this form. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the practice to obtain payment for the treatment and to carry out health care operations. The Practice explained to me that the Privacy Notice is available to me now, or in the future at my request.

The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

I understand that, and consent to, the following appointment/event reminders, and mailings, may be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; c) email reminders and newsletters to the provided email address.

The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

I understand that I have a right to request an accounting of the disclosure of my PHI other than for treatment, payment and/or health care options. I understand I may restrict access or disclosure of my PHI. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

I understand the Practice may share my PHI with the Connecticut Chiropractic Association in the event advocacy is needed for insurance claims or utilization disputes.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________________
Name of Individual (Printed)	Signature of Individual
______________________________	______________________________
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):	Relationship
Date Signed ____/____/____	Witness:______________________