

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You may refuse to sign this acknowledgement***

I, _____ have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____ TELEPHONE _____

ADDRESS _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: **Center Street Chiropractic, LLC**
Dr. Kevin D. Drumbores Telephone _____

Address: **19 Center Street** Fax: _____

Chatham, NJ 07928

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

CENTER STREET CHIROPRACTIC, L.L.C.
INFORMED CONSENT

State law requires our office to obtain your informed consent prior to examination and treatment. The purpose of this form is to inform you, not to alarm you. What you will be asked to sign is simply a confirmation of what you have been informed.

TREATMENT:

Chiropractic adjustments/manipulations: The doctor will use his hands or a mechanical device upon your body in such a way to move your joints in various directions. This procedure may cause the audible "pop" or "click" to be heard coming from your joints, which is not a cause for alarm. There are some material risks involved in doing these procedures and they are as follows:

Pain: Chiropractic treatments may result in temporary increased soreness in the area receiving treatment.

Rib Fractures: Fractures caused by chiropractic treatment are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted under x-rays, and if detected, the most appropriate gentle treatments are used, minimizing the possibility of fracture of the ribs.

Disc Injury: Chiropractic treatment is appropriate for treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatments may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at about one serious complication per 100 million low back manipulations (2).

Stroke: The overall incidence of stroke in the general population is about 2 per 1000 people (3). Although chiropractic adjustments/manipulations has been implicated as a possible cause of stroke, this possible cause is extremely rare. The best available data suggest that stroke secondary to chiropractic adjustments/manipulation may occur in one per 100,000 patients (4), a rate well below the average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal and anti-inflammatory drugs (aspirin, ibuprofen, naproxen sodium, etc) is 4 per 100,000 patients (5). The risk of serious complications of death from spinal surgeries of the back is 11.25 per 1000 patients (5). As you can see, the risk of stroke from chiropractic treatment is much lower than other common medical treatments. Even though risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

Chiropractic care is a system of health care delivery. As with many health care delivery systems we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best efforts, but if results are not acceptable, we will refer you to another healthcare provider whom we feel will assist your situation.

If you have any questions regarding the above information, please ask your doctor. When you have full understanding, please sign and date this form below.

I have been informed of the most likely complications of, and the possible undesired results of Chiropractic examination and treatment in this office and I understand them.

I hereby authorize Dr. Kevin D. Drumbore, D.C. to provide such services, as he deems reasonable and necessary.

I hereby state that I have read – or have had someone read to me – this consent form.

Patient's Signature _____ Date _____

Patient's Printed Name _____

Guardian's Signature _____ Date _____

Guardian's Printed Name _____

Witness' Signature _____ Date _____

Witness' Printed Name _____

1. Troyanovich St. Harrison DE: low back pain in the lumbar intervertebral disc: Clinical considerations for the doctor of Chiropractic. Manipulative Physical Ther 1999; 22(2):96-104
2. Shelkelle PG, Spine Update; Spinal Manipulation, Spine 1994; 854-861
3. Clayman CB. The American Medical Association Home Medical Encyclopedia, New York; Random House; 1989: 947-948
4. Dablos V. Launciri WJ. Risk assessment of cervical manipulation vs. been its NSAIDS for the treatment of back pain. J. Manipulative Physical Ther 1995; 13; 530-536
5. Horwick EL, Alter PD, Adams AH, Meeker WC, Shekelle PG, Manipulation and mobilization of the cervical spine A systematic review of the literature. Spine 1996; 21: 1746-1760.

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ First Name _____ Middle Initial

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient

3 PHONE NUMBERS

Cell Phone (_____) _____ Home Phone (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

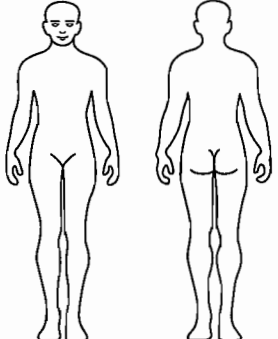
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



6

HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
				Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No		

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking _____ Packs/Day _____
 Alcohol _____ Drinks/Week _____
 Coffee/Caffeine Drinks _____ Cups/Day _____
 High Stress Level _____ Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

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MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

_____	_____	_____
_____	_____	_____
_____	_____	_____
Pharmacy Name _____	_____	_____
Pharmacy Phone (____) _____	_____	_____

YOUR RIGHTS

You have the right to:

- Revoke any Authorization, in writing, at any time. To request a revocation, you must submit a written request to the Practice's Privacy Officer.
- Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the Practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practice's Privacy Officer. In your written request, you must inform the Practice of what information you want to limit, whether you want to limit the Practice's use or disclosure, or both, and to whom you want the limits to apply. If the Practice agrees to your request, the Practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
- Receive confidential communications of PHI by alternative means or at alternative locations. You must make your request in writing to the Practice's Privacy Officer. The Practice will accommodate all reasonable requests.
- Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the Practice's Privacy Officer. In certain situations that are defined by law, the Practice may deny your request, but you will have the right to have the denial reviewed. The Practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request.
- Amend your PHI as provided by law. To request an amendment, you must submit a written request to the Practice's Privacy Officer. You must provide a reason that supports your request. The Practice may deny your request if it is not in writing, if you do not provide a reason and support of your request, if the information to be amended was not created by the Practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the Practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

PRIVACY Notice to Patients

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.

POLICY STATEMENT

This Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your medical condition and the care and treatment you receive from the Practice and other health care providers. This Notice details how your PHI may be used and disclosed to third parties for purposes of your care, payment for your care, health care operations of the Practice, and for other purposes permitted or required by law. This Notice also details your rights regarding your PHI.

USE OR DISCLOSURE OF PHI

The Practice may use and/or disclose your PHI for purposes related to your care, payment for your care, and health care operations of the Practice. The following are examples of the types of uses and/or disclosures of your PHI that may occur. These examples are not meant to include all possible types of use and/or disclosure.

- **Care** – In order to provide care to you, the Practice will provide your PHI to those health care professionals, whether on the Practice's staff or not, directly involved in your care so that they may understand your medical condition and needs and provide advice or treatment (e.g., your physician). For example, your physician may need to know how your condition is responding to the treatment provided by the Practice.
- **Payment** – In order to get paid for some or all of the health care provided by the Practice, the Practice may provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your health insurance carrier with information about health care services that you received from the Practice so that the Practice can be properly reimbursed.

- Receive an accounting of disclosures of your PHI as provided by law. To request an accounting, you must submit a written request to the Practice's Privacy Officer. The request must state a time period which may not be longer than six years and may not include the dates before April 14, 2003. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a 12 month period will be free, but the Practice may charge you for the cost of providing additional lists in that same 12 month period. The Practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.

- Receive a paper copy of this Privacy Notice from the Practice upon request to the Practice's Privacy Officer.
- Complain to the Practice, or to the Secretary of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue, S. W., Room 509F HHH Building, Washington, D.C. 20201. Or you may contact a regional office of the Office of Civil Rights, which can be found at www.hhs.gov/ocr/region.html. To file a complaint with the Practice, you must contact the Practice's Privacy Officer. All complaints must be in writing.
- To obtain more information on, or have your questions about your rights answered, you may contact the Practice's Privacy Officer.

PRACTICE'S REQUIREMENTS

The health care office:

- Is required by law to maintain the privacy of your PHI and to provide you with this Privacy Notice of the Practice's legal duties and privacy practices with respect to your PHI.
- Is required to abide by the terms of this Privacy Notice.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- Will not retaliate against you for making a complaint.
- Must make a good faith effort to obtain from you an acknowledgement of receipt of this Notice.
- Will post this Privacy Notice on the Practice's web site, if the Practice maintains a web site.
- Will provide this Privacy Notice to you free of charge upon request.

Order additional copies from
ChiroCode Institute, www.chirocode.com

- **Health Care Operations** – In order for the Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

AUTHORIZATION NOT REQUIRED

The Practice may use and/or disclose your PHI, without a written Authorization from you, in the following instances:

- 1. De-identified Information** – Your PHI is altered so that it does not identify you and, even without your name, cannot be used to identify you.
- 2. Business Associate** – To a business associate, which is someone who the Practice contracts with to provide a service necessary for your treatment, payment for your treatment and health care operations (e.g, billing service or transcription service). The Practice will obtain satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI.
- 3. Personal Representative** – To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.
- 4. Public Health Activities** – Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease, injury or disability. This includes reports of child abuse or neglect.
- 5. Federal Drug Administration** – If required by the Food and Drug Administration to report adverse events, product defects or problems or biological product deviations, or to track products, or to enable product recalls, repairs or replacements, or to conduct post marketing surveillance.
- 6. Abuse, Neglect or Domestic Violence** – To a government authority if the Practice is required by law to make such disclosure. If the Practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to prevent serious harm or if the Practice believes that you have been the victim of abuse, neglect or domestic violence. Any such disclosure will be made in accordance with the requirements of law, which may also involve notice to you of the disclosure.

- 7. Health Oversight Activities** – Such activities, which must be required by law, involve government agencies involved in oversight activities that relate to the health care system, government benefit programs, government regulatory programs and civil rights law. Those activities include, for example, criminal investigations, audits, disciplinary actions, or general oversight activities relating to the community's health care system.

- 8. Judicial and Administrative Proceeding** – For example, the Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena.

- 9. Law Enforcement Purposes** – In certain instances, your PHI may have to be disclosed to a law enforcement official for law enforcement purposes. Law enforcement purposes include: (1) complying with a legal process (i.e., subpoena) or as required by law; (2) information for identification and location purposes (e.g., suspect or missing person); (3) information regarding a person who is or is suspected to be a crime victim; (4) in situations where the death of an individual may have resulted from criminal conduct; (5) in the event of a crime occurring on the premises of the Practice; and (6) a medical emergency (not on the Practice's premises) has occurred, and it appears that a crime has occurred.

- 10. Coroner or Medical Examiner** – The Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death, or to a funeral director as permitted by law and as necessary to carry out its duties.

- 11. Organ, Eye or Tissue Donation** – If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

- 12. Research** – If the Practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI such as approval of the research by an institutional review board and the requirement that protocols must be followed.

- 13. Avert a Threat to Health or Safety** – The Practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.

- 14. Specialized Government Functions** – When the appropriate conditions apply, the Practice may use PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. The Practice may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities including the provision of protective services to the President or others legally authorized.

- 15. Inmates** – The Practice may disclose your PHI to a correctional institution or a law enforcement official if you are an inmate of that correctional facility and your PHI is necessary to provide care and treatment to you or is necessary for the health and safety of other individuals or inmates.

- 16. Workers' Compensation** – If you are involved in a Workers' Compensation claim, the Practice may be required to disclose your PHI to an individual or entity that is part of the Workers' Compensation system.

- 17. Disaster Relief Efforts** – The Practice may use or disclose your PHI to a public or private entity authorized to assist in disaster relief efforts.

- 18. Required by Law** – If otherwise required by law, but such use or disclosure will be made in compliance with the law and limited to the requirements of the law.

AUTHORIZATION

Uses and/or disclosures, other than those described above, will be made only with your written Authorization, which you may revoke at any time.

APPOINTMENT REMINDER

The Practice may, from time to time, contact you to provide appointment reminders. The reminder may be in the form of a letter or postcard. The Practice will try to minimize the amount of information contained in the reminder. The Practice may also contact you by phone and, if you are not available, the Practice will leave a message for you.

TREATMENT ALTERNATIVES/BENEFITS

The Practice may, from time to time, contact you about treatment alternatives, or other health benefits or services that may be of interest to you.