3750 Dacoro Lane, Unit 135

Castle Rock, CO 80109

NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has been provided to you.

Campbell Chiropractic, Inc. uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of your care that you receive.

Campbell Chiropractic, Inc. may use your information to provide appointment reminders, information about treatment alternatives, or other health-related issues.

Campbell Chiropractic, Inc. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, government function in order to comply with workers compensation laws, regulations, a right to request restrictions, report and retain a copy of your health records, request communication of your information by alternative means to alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to Cory Campbell and the Department of Health and Human Services if you believe your privacy rights have been violated. There will be no such retaliation for doing so.

Campbell Chiropractic, Inc. must maintain the privacy of protected information, provided you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means of by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions or complaints, please contact us.

_____ Date:_____

Patient Signature