Disclosure of Protected Health Information

Practice Name: Groskopp Chiropractic
The effective date of this Notice of Privacy Practices is 01/01/2025.

Protecting the privacy of your personal health information (PHI) is important to us. This acknowledgement is a summary of the full Notice of Privacy Practices which outlines in detail how information about you may be used and disclosed and how you can get access to this information. The full policy refers to guidelines outlined in federal mandates of Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Omnibus and is available upon request and posted on our Practice's website.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities and for treatment, payment, or practice operations. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may access copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation. You may request changes to your records. Our practice has the right to accept or deny your request. We maintain an accounting of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office. You may file a complaint about privacy violations by contacting our Office Manager.

In addition, I hereby authorize the release of information to personal acquaintances named below (and relationship) or fill in none.

1) _____ Relationship: _____

2) _____ Relationship: _____

I acknowledge that I have access to the full Notice of Privacy Practices for protected health information. I hereby grant consent for Groskopp Chiropractic to release any information necessary for my course of treatment, payment or healthcare operations.

_____

Date Printed Name Signature