PISKER FAMILY CHIROPRATIC CENTER
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HIPPA NOTICE FOR PRIVACY PRACTICES

We are required by law to maintain the privacy of Protected Health Information and provide individuals with this Notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any questions, please speak with our HIPPA Compliance Officer in person or by phone at our main number.

Your signature below is an acknowledgment that you have received this Notice of our Privacy Practices.

By signing this form, you are also allowing our office to:

1. Confirm appointments at your home by phone or answering machine;
2. Disclose medical information requested by other treating physicians;
3. Disclose medical information to your lab/insurance company;
4. Request medical records when necessary from physicians or health care facilities.

I hereby give permission to disclose health information (i.e. test results) about me to the following people: (please print name on the line provided)

Spouse: ______________________________

Son/Daughter: ______________________________

Mother/Father: ______________________________

Other: ______________________________

I have the right to withdraw or revise my permission at any time, in writing.

PRINT PATIENT NAME: ______________________________

SIGNATURE: ______________________ **Date:** ______________