



**Unbroken Body Chiropractic**  
 1280 Diamond Way  
 Concord CA 94520

**Privacy and Communication Practices 2024**

Your Information. Your Rights. Our Responsibilities.

Full disclosure of the Health Insurance Portability and Accountability Act (HIPAA) is defined by the California Department of Health Care Services (DHCS) and the United States Department of Health and Human Services (HHS). Copies of this information are available in office and online.

We will not share your information to any entity without your permission. In any instance that your protected health information (PHI) can be collected from this office while complying with the law without your permission, we will send a courtesy notice to all parties involved.

What is your protected health information (PHI)

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual

Please indicate which forms of communication you consent to have office correspondence.

<b>I <u>do</u> consent</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<b>I <u>do not</u> consent</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	to having personal information shared via Phone call Voicemail Text message Email Fax machine US Postal service
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Please indicate if you consent to the use of photos that can be used to identify you (pictures of your face, tattoos etc.) in our written or printed marketing materials, or digital content in such places as social media and our website.

<b>I <u>do</u> consent</b> <input type="checkbox"/>	<b>I <u>do not</u> consent</b> <input type="checkbox"/>	to having images of me shared via written or printed materials, in digital content
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This notice confirms you have reviewed how medical information about you may be used and disclosed and how you can get access to this information. By signing below I acknowledge I have read and reviewed my HIPAA rights, have had all my questions answered and know I can update my preferences at any time.

Print Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

I understand I may request an electronic copy of the signed document.