

**CrossWinds Chiropractic**  
**Dr. David Rheume D.C. D.A.B.C.O.**  
**15351 SE 82nd Drive**  
**Clackamas, Or. 97015**  
Ph. 503-342-6644  
Fx. 503-342-6017

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**Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU IS USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record for the care and services you receive in our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

**USE AND DISCLOSURE OF MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. For each kind of use and disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked anytime by writing to us.

We may use medical information about you to provide medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. (Example: Referrals to other physicians, referral for radiology studies., etc.)

We may use and disclose your medical information for insurance payment purposes. (Example: Private, automotive, and workers compensation insurance requesting copies of your chart notes for review before they will issue payments. Private insurance that request a treatment plan for pre-authorization.

**COURT ORDERS AND JUDICIAL AND ADMINISTRATIVE PROCEEDINGS:**

We may disclose medical information in response to a court administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials.

**PUBLIC HEALTH ACTIVITIES:**

As required by law, we may disclose your medical information to public health or legal authorities charged with prevention or controlling injury such as child abuse or neglect.

**VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE:**

We may disclose medical information to appropriate authorities if we reasonable believe that you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

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**WORKERS COMPENSATION:**

We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

**OUR LEGAL DUTY:**

Law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information and to follow the terms of the notice that is now in effect.

We have the right to change our privacy practices and the terms of this notice anytime, provided that the changes are permitted by law. Before we make the important change in our privacy practices, we will change this notice and make the new notice available upon request.

**YOUR INDIVIDUAL RIGHTS:**

You have the right to look at or get copies of your medical information. You must make your request in writing. Send your request to the contact person at the end of this notice. (\*\*If you request copies, we charge \$3.50 for each page, plus postage if you would like the copies mailed to you.) You have the right to receive a list of all the times we have shared your medical information for purpose other than treatment, payment, and health care operations and other specified exceptions. You may request that we place additional restriction on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except an emergency). Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice. You may request that we change your medical information. We may deny your request if we do not create the information you want changed or other reasons. If we deny your request, we may prove you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any further sharing of that information.

**QUESTIONS AND COMPLAINTS:**

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:**

Dr. DAVID RHEAUME, D.C.;D.A.B.C.O    Office (503) 342-6644  
15351 SE 82nd Drive                      Fax (503) 342-6017  
Clackamas, Oregon 97015

If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Health and Human Services. We will not, in any way, retaliate if you choose to file a complaint.

**ACKNOWLEDGMENT FORM:**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and have Received my copy of the notice.

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