

**Lakepoint Chiropractic L.L.C.  
1239 Upper Bear Creek Road  
Evergreen, CO 80439**

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

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

Lakepoint Chiropractic L.L.C. 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 care that you receive.

Lakepoint Chiropractic L.L.C. will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

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

Lakepoint Chiropractic L.L.C. 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, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer Douglas R. Petty and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Lakepoint Chiropractic L.L.C. must maintain the privacy of protected health information, provide you with notice of it's 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 or 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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date