Notice of Privacy Practices

Effective Date: February 16, 2026

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy
At **Marshall Back and Body Wellness Center**, we are committed to protecting the privacy and security of your protected health information (PHI). This notice explains how we may use and disclose your health information, your rights regarding your information, and our legal responsibilities.

How We May Use and Disclose Your Health Information
We may use and disclose your health information for the following purposes:

Treatment
We may use your health information to provide, coordinate, or manage your healthcare. This may include sharing information with physicians, specialists, laboratories, pharmacies, or other healthcare providers involved in your care.

Payment
We may use and disclose your health information to bill and collect payment from you, your insurance company, or another third party.

Healthcare Operations
We may use your health information to operate and improve our clinic, including quality assessment, staff training, licensing, accreditation, and business management activities.

Other Uses and Disclosures Permitted by Law
We may disclose your health information when required or permitted by law, including:

- Public health reporting
- Reporting abuse or neglect
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Coroners, medical examiners, and funeral directors
- Organ and tissue donation
- Workers' compensation claims
- To avert a serious threat to health or safety
- Military and national security activities
- As otherwise required by federal or state law

Uses Requiring Your Written Authorization
We will obtain your written authorization before:

- Using or disclosing psychotherapy notes (when applicable)
- Using your information for marketing purposes
- Selling your protected health information
- Any other use not described in this Notice

You may revoke your authorization at any time in writing, except to the extent we have already acted upon it.

Your Rights
You have the right to:

- Request to inspect or receive a copy of your medical records.
- Request corrections to your health information if you believe it is inaccurate or incomplete.
- Request restrictions on certain uses or disclosures.
- Request confidential communications by alternative means or at alternative locations.
- Receive an accounting of certain disclosures of your health information.
- Receive a paper copy of this Notice upon request.
- File a complaint if you believe your privacy rights have been violated.

Our Responsibilities
We are required by law to:

- Maintain the privacy and security of your protected health information.
- Provide you with this Notice of Privacy Practices.
- Follow the terms of the current Notice.
- Notify you if a breach occurs that may have compromised the privacy or security of your information.

We reserve the right to revise this Notice. Any revised Notice will apply to all protected health information we maintain and will be available at our clinic and on our website (if applicable).

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Marshall Back and Body Wellness Center
Address: 510 Waugh Dr., Houston, TX 77019
Phone: 713-522-1726
Email: houstonsbestchiropractor@gmail.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be penalized or retaliated against for filing a complaint.

Contact Information

If you have questions about this Notice or your privacy rights, please contact:

Privacy Officer
Marshall Back and Body Wellness Center
Address: 510 Waugh Dr., Houston, TX 77019
Phone: 713-522-1726
Email: houstonsbestchiropractor@gmail.com

Acknowledgment of Receipt

I acknowledge that I have been offered a copy of the Notice of Privacy Practices from **Marshall Back and Body Wellness Center.**

Patient Name: _____ Date: _____

Signature: _____

Date: _____

If signed by a personal representative:

Representative Name: _____ Relationship to Patient: _____

AUTHORIZATION FOR COMMUNICATION

We value your privacy and are committed to protecting your information. By signing below, you authorize **MARSHALL BACK AND BODY WELLNESS CENTER** to communicate with you via:

_____ TEXT MESSAGE

_____ EMAIL

_____ NEITHER

PLEASE PRINT:NAME: _____

PHONE NUMBER: _____

EMAIL: _____

By selecting text and/or email, I understand that I may receive appointment reminders, updates and relevant communications. I can opt-out at any time by notifying the office in writing.

_____ _____

Patient/Guardian Signature Date