Patient Name (print) _____

Acknowledgement Of Receipt Of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You may refuse to sign this acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Patient Name (Printed)

_____

Signature

_____

Date

Authorization To Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

_____ _____

Name (Printed) *Relationship*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other *(Please Specify)*

_____

_____

_____

HIPPA/HITECH/RED FLAG RULE

Privacy & Security Policies and Procedures

Revised: January 29, 2020

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT ALSO DESCRIBES WHAT POLICIES AND PROCEDURES WE HAVE TO PREVENT AND DETECT IDENTITY THEFT. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US AND WE WILL DO EVERYTHING WE CAN TO PROTECT YOUR IDENTITY.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information.

We comply with the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. We maintain a breach reporting policy and have in place appropriate safeguards to track required disclosures and meet appropriate reporting obligations. In addition we comply with the "minimum necessary" requirements of HIPPA and the HITECH amendments.

The Federal Trade Commission requires us to comply with the Red Flag Rule. This is to prevent and detect identity theft. We must follow the practices we describe in this notice and keep our policies and procedures up to date as necessary to comply with applicable laws. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION AND IDENTITIY

The following categories describe different ways that we may use or disclose your protected health information (PHI).

For Treatments: We may use your PHI and identity for treatment or disclose to a dentist, physician or other health care provider providing treatment to you, i.e. prior x-rays to a dentist we have referred you to. We will verify the identity of individuals who accompany our patients. Anyone other than a parent/legal guardian will need to provide a written/verbal authorization from parent/legal guardian and provide a photo ID or other verifying information.

For Payment: We may use and disclose your PHI and identity to obtain payment for your treatment and to conduct other payment related activities, such as determining eligibility for Plan benefits, processing your claims, coordinating benefits, etc.

For Health Care Operations: We may use and disclose your PHI and identity for other Plan operations, including quality assessment and improvement activities, reviewing your treatment, obtaining legal and audit services, detecting fraud and abuse, business planning and other general administration activities.

To Business Associates: We may disclose your health information and identity to another health care provider or organization that is subject to the federal privacy and red flag rules and that has a relationship with you to support some of our health care operations. We may disclose your PHI and identity to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud, abuse and identity theft.

Appointment Reminders: We may use or disclose your health information and/or identity to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disclosure to Others: We may use or disclose your PHI and/or identity to your family members who are involved in your treatment, payment or health operations. We may also disclose PHI and/or identity to an individual who has legal authority to make health care decisions on your behalf.

Public Benefit: We may use or disclose your PHI and/or identity as authorized by las for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities, including disease and vital statistic reporting, child abuse reporting, and FDA oversight
- To report abuse, neglect, or domestic violence
- To health oversight agencies
- In response to court and administrative order and other lawful processes
- To coroners, medical examiners, and funeral directors
- To avert a serious threat to health or safety

REQUIRED DISCLOSURES

The following is a description of disclosures of your PHI and/or identity the plan is required to make:

As required by law: We will disclose PHI about you when required to do so by federal, state, or local law.

Government Audits: We are required to disclose your PHI to the Secretary of the US Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to You: Upon request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits.

WRITTEN AUTHORIZATION

We will use or disclose your PHI and/or identity only as described in this Notice. **It is not necessary for you to do anything to allow us to disclose your PHI as described here.** If you want us to use or disclose your PHI for another purpose you must authorize us in writing to do so.

PATIENT RIGHTS

You have the following rights regarding PHI and/or identity we maintain about you:

Your Right to Inspect and Copy your PHI: You have the right to inspect and/or get copies of your PHI. You must submit your request in writing and if you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request. We may deny your request to inspect and copy PHI in certain limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed by submitting a written request to one of the Contact Persons listed below.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information (but not before April 3, 2003). That list will not include disclosures for treatment, payment, health care operation, as authorized by you, and for certain other activities.

Restrictions: Where applicable, you may request that restrictions be placed on disclosures of your PHI and/or identity. You request is not binding unless our agreement is dated and in writing.

Alternative Communication: You may request that we direct confidential communications to you in the following way: authorized person may pick up at office, can be mailed to patient's home address, or may be sent in encrypted email. You must submit your request in writing.

Amendment: If you believe that the PHI we have in our records is incorrect or incomplete, you may request that we change you PHI by submitting a written request. You must provide a reason for your request. We are not required to amend your PHI but if we deny your request, we will provide you with information about our denial and how you can disagree with the denial.

As stated in the HITECH Act complainants (i.e. patients) can share in any fines imposed on individuals and organizations.

If you pay in full (cash/credit card out of your pocket) for a service you receive from us, and you request that we not submit the claim for this service to your dental plan for reimbursement, we must honor that request.

CHANGES TO THIS NOTICE

We may amend this Notice of Privacy Practices at any time in the future and make the new Notice provisions effective for all PHI and/or identity that we maintain. We will advise you of any significant changes to the Notice. We are required by law to comply with the current version of this Notice.

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QUESTIONS, CONCERNS OR COMPLAINTS

If you want more information about our practices or have questions, concerns or complaints, please contact us using the information listed below. If you belive that:

- We may have violated your privacy right
- - We made a decision about access to your health information incorrectly
- - Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or we should communicate with you by alternative means or at alternative locations.
- - Your identity has been compromised by fault of this office.
-

You may contact us using the information listed below. You may also submit a written complaint to the US Dept. of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information and protection of your identity. We will not retaliate in any way if you choose to file a complaint with us or with the US Dept. of Health and Human Services.