

## **NOTICE OF PRIVACY PRACTICES**

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.

The United States Department of Health and Human Services, effective August 9, 2002, issued comprehensible federal regulations providing for protection of private medical information with which our office must comply. The final regulation which goes into effect April 2003 is designed to protect patient's identifiable health information. These protections are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The HIPAA privacy rules states that after April 14, 2003, health providers must provide patients with a written Notice of Privacy Practices and make a good faith attempt to obtain a written acknowledgement of such. This information should be provided to patients prior to or at the time of the first delivery of health services, except in cases of emergency. However, if a written acknowledgement is not obtainable, the attempt by the provider to obtain it is sufficient to comply with the rule.

In addition, a Notice of Privacy Practices must be displayed prominently and available for patients to take home. If the Notice is modified in the future, the new version must be displayed and available, and thereafter provided to patients at the time of their first treatment.

### **Moss Family Dental**

*Required language from the Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information. "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."*

The Health Insurance Portability and Accountability Act of 1996 required that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers also provide patients with a written Notice of Privacy Practices. This Notice is dated May 17, 2013. The privacy practices described will be in effect after this date and until or if they are replaced. Our office Privacy Practices may change from time to time. If changes are made, a new Notice of Privacy Practices will be displayed in our office and provided to patients. You may obtain additional copies of this Notice on request. Additional information may be obtained from the Contact Officer listed on this paper.

### **USES AND DISCLOSURE OF INFORMATION**

(From Department of Health and Human Services, Standards for Privacy of Individually Identifiable Health Information, Parts 160-164) The following describes how information about you may be used.

### **TREATMENT SERVICES**

We may use or provide your health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointment reminders, recommendations of treatment alternatives, information about other health services and/or other office services.

### **PAYMENT AND OPERATIONS**

We may provide your health information as required to allow for payment for services and participation, in quality assurance, disease management, training, licensing, and certification programs.

## **MARKETING**

We will not use your health information for marketing purposes without your written consent.

## **LEGAL REQUIREMENTS**

We may disclose your health information when required by law.

## **THREAT TO HEALTH AND SAFETY**

If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

## **NATIONAL SECURITY**

When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may also be provided to correctional institutes.

## **FAMILY MEMEBRS, FRIENDS, AND OTHERS INVOLVED IN CARE**

At your request, we may disclose your health information to a family member or other person if necessary to assist you with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We may also make information available so that another person may pick up filled prescriptions, medical supplies, records, and/or x-rays for you. Your information may be disclosed to assist notifying a family member, care-giver, or personal representative of your location, condition or death.

## **PATIENT RIGHTS**

You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing, addressed to the contact officer listed on this brochure. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if copies are requested to be mailed. A summary of your health information can also be requested for a fee. Details of all costs are available from the contact officer.

You may request a listing of any situations where we or our business associate disclosed your health information for purposes other than treatment, payment, or other activities for the last six years, but not before April 14, 2003. You may be charged for costs associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in a case of emergency).

If you believe that changes should be made to your health information, you must request this in writing. You must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternative format or at a specified location, you must make your request in writing.

## **PATIENT AUTHORIZATIONS**

You may give us your writing authorization to use or disclose your health information to anyone for any purpose. This authorization may be revoked, in writing, at any time. Without your writing authorization, disclosures about your health information are limited to those listed in this Notice.

If you want more information about the privacy practices of this dental office, or if you are concerned that we may have violated your privacy rights, please contact our office or the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### **\*You May Refuse to Sign This Acknowledgement\***

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

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**Print Your Name / Date**

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**Signature / Date**

I, \_\_\_\_\_, am the "personal representative" and have legal authority to make health care decisions about the following patient:

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**Please Print Patient Name Here**

### ***AUTHORIZATION FOR ADDITIONAL DISCLOSURE:***

I authorize the following individuals to have access to my health information.

	Name:	Relationship:
1)	_____	_____
2)	_____	_____
3)	_____	_____

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**Signature / Date**

### **FOR OFFICE USE ONLY**

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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

\_\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_\_\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_