PRODENTAL
FAMILY DENTISTRY

Notice of Information Practices and Patient Acknowledgement

Patient Name(please print) _____

The Health Insurance Portability and Accountability Act of 1996 **(HIPAA)** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. **HIPAA** provides penalties for covered entities that misuse personal health information.

As required by **HIPAA**, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your protected health information.

We may use and disclose your medical records only for each of the follo9wing purposes: treatment, payment, or health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would include relayed care and treatment services by health care providers, scheduling surgery, other exams or appointments with other providers, calling in prescriptions and refills, consultation between health care providers related to patients for coordination of care and physician to staff discussions for coordination of care, and the referral of a patient for health care from one health care provider to another.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, related data processing, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment
- **Health care operations** include the business aspects of running our practice on a daily basis, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any time.

The revised notice will be posted in our patient waiting areas and you will have the opportunity to request a paper or electronic copy of the revised notice from our staff, or by accessing our website.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to confirm your appointments or communicate with you in connection with care management or coordination. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to us:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to revoke it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to obtain a paper copy of this natice from us upon request.

NOTICE OF INFORMATION PRACTICES AND PATIENT ACKNOWLEDGEMENT

I have received and understand the practice's *Notice of Information Practices* written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its *Notice of Information Practices* and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Information Practices upon request.

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Signature of patient, parent, or guardian date