HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care options (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI "PHI" is information about you, including demographic information, which may identify you and that is related to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment- We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment- Your PHI will be used, as needed, to obtain payment for health care services. For example, obtaining approval for a hospital stay may require that the relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations- We may use or disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: As Required By Law; Public Health issues; Communicable Diseases; Health Oversight Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings, Law enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmate Required Uses and Disclosures; under the law, we must make disclosures to you and when required the Secretary of the Department of Health Services to Investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Users and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

The Following is a statement of our rights with respect to your PHI

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

Your physician is not required to agree to the restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to receive communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

Complaints- You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask out HIPAA Compliance Officer in person or by phone.

Your signature below is your acknowledgment that you have received the Notice of our Privacy Practices.

Signature: _____ Date: _____

Patient Name: (print) _____

The following person(s) are authorized to receive information about my account and treatment.

Name: _____ Phone #:_____

CONSENT FOR INTERNET COMMUNICATION

I grant permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintain the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any changes, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that the State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I also understand the dental practice will represent and warrant that they will, at all time during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information., and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF THE PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED AND RECEIVED USING THE SITE OR THE SERVICES.

_____ I have read the information above regarding the secured uploading of patient information to the web site for the dental (Initials) practice, and grant the dental practice permission to securely upload my patient information to the web site.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient: _____