Hilliard Advanced Dentistry
Healthy Smiles for a Lifetime

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Privacy Practice Statement

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION: PLEASE REVIEW CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our legal Duty

This is a formal notification, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information that we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Uses and Disclosures of Health Information

Your protected dental and health information (PHI) is needed to provide you with optimal care, however it can only be used or disclosed with your written consent on this registration form. We may use or disclose your health information about you for treatment, payment, and healthcare operations. For example:

Treatment. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. In addition, this may include the transmission of information upon any referral or self-referral for services of another dentist, doctor, or specialist including laboratories as the information is required as related to your treatment needs.

Payment. We may use or disclose your health information to obtain payment for services we provide you. For treatment from your identified insurance coverage, any documentation related to this process, history, progress notes, or radiographs, eligibility verification, pre-treatment inquiries and claim submission(s).

Healthcare Operations. We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities, insurance requirements, accounting and for compliance to federal, state, or city laws and regulations, appointment reminders and health related benefit services which may include mailings to your, the patient, or to labs on your behalf.

Family and Friends. For disclosure to your spouse or relative as indicated on your Patient Information Form/ Health History concerning any related health care information unless otherwise indicated. This may be modified at any time orally followed by written consent. We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. PLEASE NOTE THAT CONSENT IS NOT REQUIRED FOR EMERGENCY CARE OR TREATMENT. AN EMERGENCY IS DEFINED AS A DENTAL CONDITION THAT HAS BEEN DETERMINED BY THE DENTIST TO REQUIRE IMMEDIATE AND FULL INFORMATION FOR CARE ON YOUR BEHALF.

Your Authorization. In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we can not use or disclose your health information for any reason except those that are described in this Notice. Required by law enforcement agencies, for example gun shot wounds, domestic violence and victims of abuse or neglect, etc. Any information used for public health purposes, medical examiners or related to a person's death for the purposes of the health department or disease tracking.

Marketing Health-Related Services. We will not use your health information for marketing communications without your written authorization. Any information used for health care oversight, such as a site review by the dental board, OSHA, the EPA or an insurance company. Any information related to tracked research procedures (i.e. biopsies) through The Ohio State University. Please note that the information is customarily stripped of any personal date, and is normally generic (age, sex, diagnosis) in nature.

I further understand that if the photographs, slides and videos are used in any publication or as part of a demonstration, my name or other identifying information will be kept confidential. I don't expect compensation, financial or otherwise, for the use of these photographs, slides and videos.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Change of Ownership. In the event that this practice is sold or merged with organization, your health information/record will become the property of the new owner.

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

PATIENT RIGHTS

Your rights with respect to your protected health information.

- The right to request limits on uses and disclosure at registration or at any time during your care.
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information. Copies, billable staff time, and postage fees may apply.
- The right to get a listing of who we have made disclosures to about your PHI.
- The right to correct and update your file through an amendment process.

We reserve the right to modify or change this Privacy Statement and process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice. An updated Privacy Notice will be posted in the office within 60 days of the revision.

QUESTIONS AND COMPLAINTS

If you have any concern or complaint bout how your protected health information is being used, from this time forward, you should first contact your office to see if we can resolve your concerns.

If you feel your rights have been violated please contact our office and complete a complaint form for review and discussion. If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights
Regional Manager
Department of Health & Human Services
Chicago, Illinois 60601
(312) 886-1807

This Privacy Plan is a working draft, which became effective on April 14, 2003.

I have read the privacy Notice and understand my rights contained within this notice.

By way of my signature, I provide the practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

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Patient Name (print)

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Signature of Patient, Parent or Guardian **Date**

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Authorized Facility Signature **Date**
HIPAA Compliance

PATIENT'S REQUEST FOR RELEASE OF DENTAL INFORMATION

I, (____________________), would like to allow the following person(s) access to my protected health information. I understand that to change this request I must make a request to this office to do so. Such requests should be made in writing and signed. Verbal requests may be allowed if followed up by a written and signed request.

____

Name Relationship

____

Name Relationship

____

Name Relationship

____

Patient's Signature **Date**