

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We use and disclose health and general information about you for treatment, payment, insurance 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.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Insurance: We may release general information about you to obtain insurance and claim information.

Healthcare Operations: We may use and 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.

Your Authorization: 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.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

To Your Family and Friends: We may disclose your health information to a family member, friend or other person but only if you agree that we may do so. This can be a written authorization or verbal consent between the patient and the practice.

To ensure the privacy of others, we ask that you sign this agreement stating you understand these regulations and will abide by them. Due to the patient sign in sheets, location of operator rooms and check out centers, we ask that you respect the privacy of others and their health information which consist of, but not limited to: treatment plans, appointment reminders, insurance inquiries, payment methods, etc.

Your signature below establishes that you have read and understand this agreement and will comply with office policies concerning patient privacy as well as your own. Your signature is written authorization to permit South Suburban Dental and Sleep Center and its entities the right to release personal and health information to other healthcare facilities, person(s) and organizations related to your treatment when deemed necessary.

PATIENT'S EMAIL:

(appointment reminders, discount offers/promos, special events, huge saving opportunities, answers to questions)

Patient Signature

Date

Guardian Signature

(only if patient is a minor)

Please list the person (s) below to which you authorize the staff at South Suburban Dental and Sleep Center to release information to and the relationship of that person to the patient. (please print)

1) _____ Relation: _____

2) _____ Relation: _____