Sunshine Family Dentistry

812-280-7500
1005 East Lewis & Clark Parkway
Clarksville, IN 47129

Notice of Privacy Practices (Condensed Version)

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures.

Sunshine Dental is permitted to use and disclose your private and confidential health information for treatment, payment and dental care operations of the Practice. For example, the Practice may disclose your protected dental information to other dentist to facilitate treatment, and the Practice may use dental information about you so that the Practice may bill and collect payment from an insurance company, dental plan or other third party payer. The Practice may disclose your dental information to review treatment and services to evaluate performance of Practice staff and other management and administrative purposes. In addition, the Practice may use or disclose your protected dental information which is incident to a permitted use or disclosure. "Protected dental information" is information about you that may identify you and relates to your past, present or future dental needs.

Uses and disclosures requiring an opportunity for you to agree or object,

The Practice may use and disclose your health information in the following instances. In each of these examples, you have the opportunity to agree to or prohibit or restrict the use or disclosure. If you are not present or able to agree or object the use or disclosure, the practice may determine whether the disclosure is in your best interest. Emergency disclosures may also be made – due to your incapacity or emergency treatment situation – if disclosure is consistent with your prior expressed preference and in your best interest as determined by the Practice.

Facilities Directory.

Unless you object, the Practice will use and disclose certain area of your health information to maintain a directory of patients.

Family Members.

Unless you object, the Practice will disclose your health information to a family member, other relative, close friend or other person you identify; such information disclosed will be directly relevant to such person's involvement with your health care. If you are unable to unavailable to agree or object, the Practice may disclose information as necessary if the Practice determines it is in your best interest. The Practice may use or disclose information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or other responsible person for your care, your address or phone number, general condition or death.

Disclosures made without your authorization or consent.

The following is a description of other purposes for which the Practice is permitted or required to use or disclose your protected health information without your consent, authorization or your opportunity to object; this is not a complete list of all possible disclosures.

1. By the Practice for training or to defend itself in a legal action or other proceeding brought by you.
2. In the course of any judicial or administrative proceeding and for law enforcement purposes.
3. Treatment, payment, and dental operations

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization at any time, provided that the revocation is in writing, except to the extent that (1) the Practice has taken action in reliance thereon; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. Also, uses and discloses may be further limited by more stringent Kentucky or Indiana Law involving privacy protection. Under Indiana law, the Practice my withhold information requested by a patient if the Practice-reasonably determines that such information (1) detrimental to the physical or mental health or the patient or (2) likely to cause the patient to harm him/her or another.

Individual Rights.

The following are statements of your privacy rights. In each, you may exercise these rights by filing a written request to the privacy contact listed below.

1. You have the right to request restrictions on certain uses and disclosers of your protected health information: the Practice is not required to agree to a requested restriction.
2. You have the right to receive confidential communications of your protected health information
3. You have the right to inspect and copy your protected health information.
4. You have the right to amend your protected health information
5. You have the right to receive an accounting of certain disclosures of your protected health information.
6. You have the right to obtain a paper copy of this notice from the Practice.

Practice Duties.

The Practice is required by law to maintain the privacy of your protected dental information and to provide you with this notice of its legal duties and privacy practices with respect to protected health information. The Practice is required to abide by the terms of the privacy notice currently in effect. The Practice reserves the right to change the terms of its privacy notice and to make the new notice provisions effective for all protected health information that the Practice maintains. Any such revised notice shall be provided to individuals in the same manner this notice is given.

Complaints and Contact.

If you believe that your HIPAA privacy rights have been violated, you may make a written complaint by delivery to the Practice and to the Secretary of HHS. You will not be retained against if you file a complaint. You should file your complaint at the following address and you may also request further information by written request to:

Sunshine Family Dentistry
1005 East Lewis and Clark Parkway
Clarksville, IN 47129

** *The Notice of Privacy Practice in its entirety is available upon request.*

HIPAA Privacy Notice Procedure Notice
Acknowledgment of Receipt

This is to acknowledge my receipt of the HIPAA Privacy Notice delivered to me by Sunshine Dental.

_____
Patient Name (Please Print)
If Patient is a Minor, Responsible Party Name (Please Print)

_____
Signature

_____
Date

_____
Responsible Party Relationship to Patient