

Carl C. Druskovich, DDS
45140 M-51 West
Decatur, MI 49045

PRIVACY NOTICE TO OUR PATIENTS

Carl C. Druskovich, DDS and staff of this office strongly believe in protecting the confidentiality and security of information we collect about you. This notice describes our privacy policy and describes how we treat the information we receive about you.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all dental records and other 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. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", 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 health information.

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

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services.

We may also call your name in the waiting room when the doctor or hygienist is ready to see you for your appointment. We may contact you by phone or other means to confirm or cancel an appointment or to provide results from exams or tests.

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.

You have the following rights with respect to your dental information, which you can exercise by presenting a written request:

- The patient has the right to inspect their dental records and to also obtain copies of the information in their record.
- The patient has the right to request an amendment to their protected dental information. The practice, in turn, has the right to deny a requested amendment.
- The patient has the right to authorize or designate a personal representative in writing to make decisions related to their dental care on behalf of the individual.
- The patient has the right to request a restriction for any part of their protected dental information. This also includes a patient's ability to request information not to be disclosed to family members or friends who may be involved in their care. We are, however, not required to agree to this request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and related services by one or more health care providers.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations.

I have received a Notice of Privacy Practices from the practice of Carl C. Druskovich, DDS containing a more complete description of the uses and disclosures of my health information.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

PATIENT NAME :

RELATIONSHIP TO PATIENT:

SIGNATURE :

DATE :

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:

Initials:

Reason:
