

## **STATEMENT OF PRIVACY PRACTICES**

We, at Highland Family Dental, are dedicated to protect the privacy rights of our Patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

### **PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA). This includes issues relating to your treatment, payment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose but it will never otherwise be given to anyone, even family members, without your written consent. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

### **COLLECTING PROTECTED HEALTH INFORMATION**

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone numbers, Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

### **DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION**

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

**PATIENT RIGHTS**

You have a right to get copies of your healthcare information, to obtain copies in a variety of formats, and to a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient of Dr. Stephen S. Cho at Highland Family Dental. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Stephen S. Cho, DDS. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the office’s health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

The Notice of Privacy Practices is also posted in the facility.

Highland Family Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

**ADDITIONAL DISCLOSURE AUTHORITY**

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

<b>ANY MEMBER OF MY IMMEDIATE FAMILY</b>	YES	NO
<b>SPOUSE ONLY</b>	YES	NO
<b>OTHER (please specify)</b>	YES	NO

**Patient Name:**

**Date:**

**Patient/Guardian Signature**