

PLEASE READ AND REVIEW THE BELOW INFORMATION.
THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

Island Dental Center of Summerlin
NOTICE OF PRIVACY PRACTICES

THIS NOTICE SERVES TO INFORM PATIENTS HOW HEALTH INFORMATION WILL BE USED AND DISCLOSED IN THE PRACTICE AND HOW YOU MAY GET ACCESS TO THIS INFORMATION IF NEEDED.

FEDERAL AND STATE REQUIREMENTS (Effective April 14, 2003)

Federal and state law requires us to ensure and maintain the privacy of your health information. This same law also requires us to give you notice about our privacy practices, legal duties, and your rights concerning your health information. We are expected to follow the privacy practices we describe in this notice while it is in effect.

We reserve the right to change our privacy policies and any associated terms of this notice at any time provided any changes in the law will allow us to do so. We also reserve the right to make changes in our privacy policies and the new terms of our notice shall be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we carry out any significant changes in our policies, we will change this notice and make the new one available upon request.

HOW YOUR HEALTH INFORMATION WILL BE USED

We may use and disclose health information for treatment, payment and health operations named below:

Treatment: We may use health information to ensure proper treatment and/or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and/or disclose health information to procure payment for services provided to you. We may also disclose your health information to another health care provider or related entity that is subject to federal Privacy Rules for its payment activities.

Appointment Messages/Reminders: We may use or disclose your health information to provide you with appointment messages/reminders (example: voicemail messages, postcards, emails, etc.)

Family and Friends: We may disclose information about your health information to a family member, friend or other person to the extent needed to help with your health care or with payment with your health care. You will have the opportunity to object to our use or disclosure of health information with these people if need be. If you are not present, however, or in the event of an emergency and/or incapacity, we reserve the right to disclose your medical information base on our professional judgment of whether distribution of such information would be in your best interest. In addition, we may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays or other related forms of health information. We may also use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Permission to Disclose Health Information: The patient at any time can give us written authorization allowing us to disclose health information to anyone for any purpose. This authorization may be revoked at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while in effect. Unless you give us a written authorization we cannot use or disclose health information for any reason except those described in this notice.

Island Dental Center Health Care Operations: We may use and disclose your health information for our health care operations. (Examples of health care operations: credentialing activities, certification, licensing, accreditation, training programs, quality assessment, review of competence of health care professionals, evaluating practitioner and provider performance.) We may use health information to another health care provider that is subject to federal privacy rules and has a relationship with you to support some of their health care operations. We may disclose your information help these organizations conduct quality assessment and improvement activities, reviews competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

Disaster Relief: We may use or disclose your health care information to any public or private entity authorized by law or by its charter to aid in disaster relief efforts.

Public Benefit: We reserve the right to use or disclose your health information as authorized by law for the following purposes deemed to be in the public interest:

- As required by law.
- To report adult abuse, neglect or domestic violence.
- Public health activities including disease and vital statistic reporting, child abuse, FDA oversight, and to employers regarding work related illness or injury.
- To organ procurement organizations.
- To stop a serious threat to health or safety.
- To correctional institutions regarding inmates.
- As authorized by state worker's compensation laws.
- Coroners, medical examiners and funeral directors.
- Health oversight agencies.
- In response to court orders or other lawful processes.
- Law enforcement officials pursuant to subpoenas and other lawful processes.
- In connection with research activities deemed lawful and under strict federal guidelines.
- To military and to federal officials for lawful intelligence, counterintelligence and national security activities.

PATIENT RIGHTS

You have the right to look at or get copies of your health information with some exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. Please indicate to the front desk if you do wish to have a copy of your health information picked up or sent to another health care provider.

You have the right to request that we place additional restriction on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in cases of an emergency or lawful actions). Any agreement we make to a request for additional restrictions must be agreed to by an authorized officer of Island Dental Center and signed in writing. Your request is not binding unless our agreement is in writing.

You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosure for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request an account more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to your request.

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

You have the right to have us amend your health information. Your request must be in writing and it must explain why we should amend the information. We may deny your request under certain circumstances.

If you need more information about our privacy practices or have questions or concerns, please contact us at the office.

If you are certain that:

- We have violated your privacy rights.
- We have made a decision about access to your health information incorrectly.
- We should communicate with you by alternative means or at alternative location.
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect.

You may contact us at the office. You may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a notice of Privacy Practices from Island Dental Center of Summerlin.

Signature: X _____ Date: _____

If a personal representative signs this authorization on behalf of the individual complete the following:

Personal Representative: _____

Relationship to Individual: _____

For Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____