NORTHERN SMILES FAMILY DENTAL

NOTICE OF PRIVACY PRACTICES (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOU HEALTH INFORMATION IS IMPORTANT TO US.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you

- Get an electronic or paper copy of your dental record
    - You can ask to see or get an electronic or paper copy of your dental record and other health information we have about you. Ask us how to do this
    - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee
- As us to correct your dental record
    - You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
    - We may say “no” to your request, but we’ll tell you why in writing within 60 days
- Request confidential communications (must have in writing)
    - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
    - We will say “yes” to all reasonable requests
- Ask us to limit what we use or share
    - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care
    - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information
- Get a list of those with whom we’ve shared information
    - You can ask for a list (accounting) of the times we’ve shared your health information for six (6) years prior to the date you ask, who we shared it with, and whyWe will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months
- Get a copy of this privacy notice
    - You can ask for a paper copy of this notice any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly
- Choose someone to act for you (must have in writing)
    - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information

    - We will make sure the person has this authority and can act for you before we take any action
- File a complaint if you feel your rights are violated
    - You can complain if you feel we have violated your rights by contacting us
    - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1 (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
    - We will not retaliate against you for filing a complaint

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. (must be in writing)

- In these cases, you have both the right and choice to tell us to:
    - Share information with your family, close friends, or others involved in your care
    - Share information in a disaster relief situation
    - Include your information in a hospital directory

      If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us specific written permission
    - Marketing purposes
    - Sale of your information
    - Most sharing of psychotherapy notes
- In the case of fundraising
    - We may contact you for fundraising efforts, but you can tell us not to contact you again

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- Treat you
    - We can use your health information and share it with other professionals who are treating you
- Run our organization
    - We can use and share your health information to run our practice, improve your care, and contact you when necessary
- Bill for your services
    - We can use and share your health information to bill and get payment from health plans or other entities

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

- Help with public health and safety issues
    - We can share health information about you for certain situations such as:
        - Preventing disease
        - Helping with product recalls

        - Reporting adverse reactions to medications
        - Reporting suspected abuse, neglect, or domestic violence
        - Preventing or reducing a serious threat to anyone's health or safety
- Do research
    - We can use or share your information for health research
- Comply with the law
    - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law
- Respond to organ and tissue donation requests
    - We can share health information about you with organ procurement organizations
- Work with a medical examiner or funeral director
    - We can share health information with a coroner, medical examiner, or funeral director when an individual dies
- Address workers' compensation, law enforcement, and other government requests
    - We can use or share health information about you:
        - For workers' compensation claims
        - For law enforcement purposes or with a law enforcement official
        - With health oversight agencies for activities by law
        - For special government functions such as military, national security, and presidential protective services
- Respond to lawsuits and legal actions
    - We can share health information about you in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon receipt, in our office.

This Notice of Privacy Practices applies to the following organizations:

Northern Smiles Family Dental
1297 Main Street, Suite 3
Windsor, CO 80550
Ph: (970) 686-7775
Web site: www.NorthernSmilesFamilyDental.com

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

DESCRIPTION OF PERSONAL REPRESENTATIVES AUTHORITY

1. Please list who you want to have access to your pertinent medical information. (i.e.: family member, spouse, significant other)

2. May we leave message on answering machine? YES NO

3. Preferred method of contact? HOME PHONE CELL PHONE EMAIL

Home #_____ Cell #_____ Work #_____

Home #_____ Cell #_____ Work #_____

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by our office and how I may obtain access to and control this information.

X_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

X_____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____
DATE