

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect on May 1st, 2009, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at anytime, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

We may request a copy of our Notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To your family and friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons involved in care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing health-related services:** We will not use your health information for marketing communications without your written authorization.

**Required by law:** We may use, or disclose your health information when we are required to do so by law.

**Abuse or neglect:** We may disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety, or the health and safety of others.

**National security:** We may disclose to Military Authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized Federal Officials health information required for lawful intelligent, counter intelligent, and other national activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment reminders:** We may use or disclose your health information to provide you with appointment reminders, such as voicemails, post cards, or letters.

## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photo copies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

**Disclosure accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14th, 2003.

**Restriction:** You have the right to request that we place additional restrictions 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 when in an emergency).

**Alternative communication:** You have the right to request that we communicate with you about your health information by alternative means or alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations and provide satisfactory explanation how payments will be handled under the alternative means or locations you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information must be amended.) We may deny your request under certain circumstances.

**Electronic notice:** If you receive this notice on our website or by e-mail, you are entitled to receive this notice in written form.

**Questions and complaints:** If you would like more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request made to amend or restrict the use or disclosure of your health information or to have us communicate with by alternative means or locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## PATIENT

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

### PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

**PURPOSE OF CONSENT:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

**NOTICE OF PRIVACY PRACTICES:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information and other important matters about your protected health information.

A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice and our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice by contacting our office by phone (520) 297-2007 or email [office@orovalleydentals.com](mailto:office@orovalleydentals.com).

**RIGHT TO REVOKE:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to [office@orovalleydentalarts.com](mailto:office@orovalleydentalarts.com). Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if consent is revoked.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

REPRESENTATIVE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



(520) 297-2007 [office@orovalleydentals.com](mailto:office@orovalleydentals.com)

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