FOREST HILLS

DENTAL CARE

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your case by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of progress to your insurance company.

We may share your medical information with our business associates, such as a billing service. We may have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send postcards or other information. We may also want to call to remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fill your request.

You have the right to know of any used or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You must sign a release form for the information.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us your written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for copies.

You have the right to request amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add your information.

You have a right to receive a copy of this notice. If you would like a copy, please ask the receptionist. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer (see on back for contact information.)

This notice goes into effect as of April 4, 2003.

Acknowledgement: I have received a copy of this office's Notice of Privacy Practices.

In order to prevent unauthorized access to your patient's vital information, we have established an identity theft program. All vital documents both paper and electronic will be shredded prior to disposal. No credit card numbers will be kept on file. Checks will be kept in a safe place and any copies will be destroyed properly. Charts will be kept in a secure area with an alarm system to prevent theft. Patients will be notified if there is a breech in our identity theft program.

Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient(s): _____

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