



## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE, EFFECTIVE SEPTEMBER 23, 2013, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This practice is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

### DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

**Treatment:** We may use or disclose your health information to another dentist or healthcare provider within our practice that may be providing treatment to you or if we refer you to another health care provider outside of our practice.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information (i.e. specific treatment procedures) with your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment.

**Use and Disclosure of Health Information Required by Law:** We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

**Marketing Health-Related Services:** We will not use or sell your health information for marketing communications without your specific written authorization.

**Contacting You:** We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us, however any message will be limited to only the necessary information required to contact you or confirm your appointment.

**Health-Related Services:** We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. **You have the option of opting out of these communications.**

**Your Authorization:** As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. 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 any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

## PATIENT RIGHTS

**Right to See and Copy Your Health Information:** You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated.

**Right to Accounting of Disclosures of Your Health Information:** You have the right to receive a list of instances in which our business associates or we disclosed your health information for purposes other than treatment, payment, and healthcare operations.

**Right to Request Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

**Right to Request Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request.

**Right to Request Amendment:** You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended..

**Right to Written Notice:** If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

**Patient's right to restrict information:**

A patient may request that certain disclosures of Protected Health information to a health plan where the patient pays out of pocket in full for the particular service.

**Breach Notification:**

Simply Beautiful Smiles takes patient privacy extremely seriously. If, despite our best efforts, a patient's private information is breached in any way, we will notify the patient whose information has been breached immediately following discovery of said breach.

Acknowledgment of Privacy Notice:

_____	_____	_____
Name (print)	Signature	Date
_____	_____	_____
Witness (print)	Signature	Date