



NOTICE OF PRIVACY ACT PRACTICES

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 AS THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSES OF HEALTH INFORMATION

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

Treatment: We may use or disclose your health information to physician or other healthcare provider providing treatment to you or to family and friends you approve.

Payments: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare operation: 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 qualification of health professional evaluating practitioner and provider performance, conduction training program, accreditation, and certification, licensing or credentialing activities.

Your Authorization in addition to our use of health information for treatment payment of healthcare operations. You may give us written authorization to use your health information or to disclose it to anyone for any purposed. You also have the right to request restriction on disclosure of PHI (Personal health information) or alternative means of communication to ensure privacy.

Marketing related health services: WE will not use your health information when we are required to do so bylaw or national security activity.

Abuse or Neglects: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcard, letter or texting messages)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with exceptions. If you request copies a fee may be charged to release your information.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated you privacy rights, or you disagree with a decision we mad about access to your health information or In response to a request you made to amend or restrict the use of disclosure of health information or to have us communicate with you by alternative means or alternate locations you may complain to the contact information listed at the end of the notice.

You also may submit a written complaint to the US department of health and human services upon request

We support yor right to the privacy of your health information. We will not retaliate to anyway if you choose to file a complaint with us to the Department o f Health and human services.

ON BEHALF OF MY CHILD, WHO IS A MINOR, I HAVE READ AND CONSENT TO THE USE AND DISCOLOSR OF MY PERSONAL HEALTH INFORMATON BY YOUR OFFICE DURING TREATMENT, BILLING/PAYMENT AND DENTAL OFFICE OPERATION AS OUTLINED IN THE NOTICE OF PRIVACY PRACTICES.

Print Name

Signature of Parent or Guardian