ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PURPOSE: this form is used to obtain acknowledgement of receipt of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I ______________________________ HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

PRINT NAME: ______________________________

SIGN: ______________________________

DATE: ______________________________

AUTHORIZATION TO RELEASE INFORMATION

PURPOSE: this form is used to obtain authorization to release information regarding you covered under the privacy act to people other than yourself,

I, ______________________ authorize the following person(s) to have access to information covered under the privacy practice regarding myself.

Print Name & Relationship______________________________

Print Name & Relationship______________________________

Print Name & Relationship______________________________

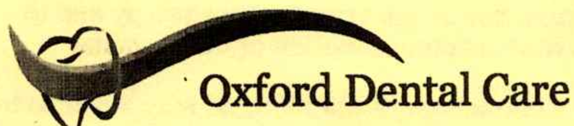
We attempted to obtain written acknowledgement or receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Patient Name: ______________________

- ❑ Individual Refuses to Sign
- ❑ Communication Barriers – prohibited obtaining the acknowledgement
- ❑ Emergency Situation – prevented us from obtaining the acknowledgement
- ❑ Other – please explain: ______________________________
  ____

______________________________ ______________________

Employee Signature Date



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

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will abide by the terms of this notice and we reserve the right to change this notice and to make any new notice effective for all protected 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 the make the new one available to you. You may request a copy of our notice at any time.

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 use or disclose your health information to a physician or other healthcare provider providing treatment to you. We will also provide your physician or healthcare provider with copies of various reports that should assist him/her in treating you once you are in his/her care.

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

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 any time. Your revocation will not affect any use of disclosures permitting 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.

Communication with Family: 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.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include dental labs and other dental specialists, which include but are not limited to orthodontists, oral surgeons, periodontists, and endodontists. We may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information and we only disclose health information that is directly relevant to that person's involvement in your healthcare.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Correctional Institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary for your health, and the health and safety of other individuals.
Law Enforcement: We may disclose health information for law enforcement purposes as required by law, or in response to a valid subpoena
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice messages, postcards, or letters).

YOUR PATIENT RIGHTS:

Although your health record is the physical property of the healthcare provider or facility that compiled it, the information belongs to you. You have the right to:
***request a restriction on certain uses and disclosures of your information**
***obtain a copy of your health record and/or disclosures of your health information**
***amend your health record**
***request communications of your health information by alternative means or at alternative locations**
***revoke your authorization to use or disclose health information except to the extent that action has already been taken**

QUESTIONS AND/OR COMPLAINTS:

If you have questions regarding your privacy rights or if you feel that we have violated your privacy rights, please contact us. You may also file a complaint with the Secretary of the Department of Health and Human Services.
Source: AHIMA Practice Brief, "Notice of Information Practices" (November 2002)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I understand that Oxford Dental Care may use or disclose my health information for treatment purposes, in order to receive payment, and for other healthcare operations. I have been given a copy of the notice of privacy practices that describes how my health information is used and shared. I understand that this office has the right to change this notice at any time. I may obtain a