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& Associates, PA  
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Account # \_\_\_\_\_

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## 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 Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- ❖ Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- ❖ Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- ❖ Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- ❖ In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;
- ❖ If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or
- ❖ If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ❖ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ❖ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ❖ The right to inspect and copy your protected health information.
- ❖ The right to amend your protected health information.
- ❖ The right to receive an accounting of disclosures of protected health information.
- ❖ The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of \_\_\_\_\_, and we are required to abide by the terms of the Notice of Privacy currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Janice G. Dickerhoff  
Administrator  
Spring Lake Dental Group  
David G. Dickerhoff, DDS & Associates, P.A.  
103 Superior Drive  
Spring Lake, NC 28390  
(910) 497-3200

For more information about HIPAA  
or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

## Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- ❖ Obtain payment from third-party payers
- ❖ Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

# Patient Authorization Form

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

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Person or entity requesting the information and authorized to make the requested use or disclosure:

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Recipient of the information: \_\_\_\_\_

This information is being requested for the following purpose(s):

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This authorization shall remain in effect from the date signed below until \_\_\_\_\_  
(expiration date or event).

I understand that:

- ❖ I may inspect or copy the protected health information to be used or disclosed
- ❖ I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- ❖ Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- ❖ I may refuse to sign this authorization and that you will not continue treatment or payment on me providing this authorization (except to the extent that the authorization is research-related treatment, in which case you may refuse to provide that research-related treatment).

\_\_\_\_ If checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient (if signed by personal representative of Patient): \_\_\_\_\_

Date: \_\_\_\_\_