Implant Dentistry and Perio Rehab

2106 Virginia Drive, Ste A
Wichita Falls TX 76309

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition or;
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials' health information required for lawful intelligence, counterintelligence, and other national security activities. We disclose to correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient.

Secretary of HHS: We will disclose your health information to the Secretary of U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relation to worker's compensation to other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits investigations, inspections, and credentialing as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful purposes instituted by someone else involved in the dispute, but only if efforts have been made, either by the requested party, or us, to tell you about the request or to obtain an order protecting the information requested.

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical

examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Marketing: We may contact you to provide you with information about our products, services, and disease information related to oral care as permitted by applicable law. If you do not wish to receive such information from us, *you may opt out of receiving our marketing communications.*

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purpose other than those provided for in this Notice (or as otherwise permitted or required by law.) You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide paper or photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and former you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage. If you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit a written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment of health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request.

File a Complaint: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
We will not retaliate against you for filing a complaint.

Patient Authorization to Disclose Protected Health Information (PHI)

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Texas law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

NAME OF PATIENT

Full Name: _____

Other Name(s) Used: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Email (*Optional*): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

☐ Implant Dentistry & Perio Rehab
Dr. William S. Neale, DDS., MD
2106-A Virginia Dr. Wichita Falls TX 76309 (940) 322-0758

☐ Other: Name/Organization: _____
Address: _____
Phone: _____ Fax: _____

WHO CAN RECEIVE APPOINTMENT RELATED INFORMATION?

☐ SELF ONLY (PATIENT)
☐ OTHER: INDICATE RELATIONSHIP: _____

Other Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email Address: _____

Appointment Notifications / Reminders are to be received by means of: (check all that apply)

☐ Telephone Call ☐ Voicemail ☐ SMS / Text Message ☐ Mail ☐ Email

WHO CAN RECEIVE AND THE USE THE HEALTH INFORMATION?

☐ SELF (PATIENT)
☐ THIRD PARTY

Third Party Name: _____ Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Information is to be received by means of:

☐ Mail ☐ Fax ☐ Receive in Person ☐ USB Flash Drive ☐ Encrypted Email ☐ Other: _____

WHAT INFORMATION IS BEING DISCLOSED? (Processing Fees Apply for Duplication*)

☐ Dental Record from (insert date) _____ to (insert date) _____ or for condition described: _____

☐ Entire Dental Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

☐ Copy of Complete Dental Chart ☐ Copy of Dental X-Rays ☐ Other: _____

REASON FOR RELEASE OF INFORMATION (CHOOSE ALL THAT APPLY):

☐ Treatment/Continuing Medical Care ☐ Personal Use ☐ Billing or Claims ☐ Insurance ☐ Legal Purposes

☐ Disability Determination ☐ School ☐ Employment ☐ Other *(Specify)* _____

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this Authorization at any time, except to the extent that action has already been taken to comply with it. With my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on _____ (date supplied by patient; or _____ if revoked in writing by patient; or _____ 180 days from the date hereof; or _____ under the following conditions: _____..)

It is understood by Implant Dentistry and Perio Rehab that I authorize the release of my PHI by Implant Dentistry and Perio Rehab for the purposes of appointments, billing, marketing, and continuity of care. I understand that I may revoke my authorization for specific activities in writing to Implant Dentistry and Perio Rehab in accordance with the Notice provided.

Patient/Legal Representative: _____ Date: _____