Central Dental Group P.C.

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.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, or legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on January 1, 2018, and will remain in effect until we replace it.

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. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all 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 make the new Notice available upon request.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use and disclose your health information to a physician or other health care provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. We use joint accounts for all family members. This may disclose your treatment to other family members.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvements activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, accreditation, certification, licensing, or credentialing activities.

Your Authorization: You may give us written authorization to disclose your health information to any one for any purpose. If you give us authorization you may revoke it at any time. Your revocation will not affect any disclosures permitted while your authorization was in effect.

Family, Friends, and Others: We may disclose your health information to a family member, friend, or other person involved with your health care to the extent necessary to help with your health care, location, general condition, death, or with payment for your health care. If you are present and able to communicate clearly you will be given the opportunity to object. In the event of your incapacity or in emergency circumstances, we will disclose health information as necessary and relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person pick up medical supplies, x-rays, or other similar forms of health care.

Marketing: We will not use your health information for marketing communications without your written consent.

Required By Law: We will use or disclose your health information, for any reason, when required by law to do so.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or safety or the health or safety of others.

Job Shadowing: We may at times have individuals interested in Dentistry as a career observing care in our office. Your health information may be disclosed to them. They are required to observe all privacy regulations.

Other: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to a correctional institution or law enforcement official having lawful custody of the patient the health information of inmates.

PATIENT RIGHTS

ALL REQUESTS FOR INFORMATION MUST BE MADE IN WRITING

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge you for a reasonable cost-based fee for expenses such as copies, staff time, and postage. If you request an alternative format, we may charge a cost-based fee for that format. If you prefer, we will, for a fee, prepare a summary or an explanation of your health information.

Disclosure: You have the right to receive a list of instances, for the last six years, in which we or our business associates disclosed health information, for purposes other than those listed above. If you request this information more than once in a 12-month period, we may charge you a reasonable, cost-based fee.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Please specify the alternative means or locations.

Amendment: You have the right to request that we amend your health information. You must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website (cdgpc.com) or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you have any questions or are concerned that we may have violated any of your privacy rights, you may contact us at the address below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to privacy concerning your health information. We will not retaliate in any way if you chose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION

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Central Dental Group P.C.

Consent for Use and Disclosure of Health Information

Patient's Name_____ Birth Date_____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy of this Notice accompanies this consent. We encourage you to read it completely before signing this consent.

A copy of the Notice of Privacy Practices is available to you upon request.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to any business office personnel. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I give my consent to release my health information to the following persons: _____

_____

SIGNATURE:

I have had full opportunity to read and consider the contents of this Consent Form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Name-Please Print _____

Signature_____ Date_____

If this consent is signed by a person other than the patient, please complete the following:

Relationship to Patient:

___ Parent

___ Power of Attorney

___ Guardian

___ Foster Parent

A COPY OF YOUR SIGNED CONSENT IS AVAILABLE UPON REQUEST