



## **STATEMENT OF PRIVACY PRACTICES**

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policy and practices but will always inform you of any changes that might affect your rights.

### **Protecting Your Personal Healthcare**

We use and disclose the information we collect from you only as allowed by the Health Insurance and Accountability Act and the state of Virginia. This includes issues relating to your treatment, payment and our dental care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed to release.

### **Collecting Protected Health**

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. The information we collect from you will always be protected to the full extent of the law.

### **Disclosure of Your Protected Health**

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointment including voicemail messages, answering machines, and postcards.

### **Patient Rights**

You have a right to request copies of your healthcare information; to request copies in a variety of formats and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above all such requests must be in writing. We may charge for your copies in amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.

**NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT**

Patients Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I understand that, under the Health Insurance Portability Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy.

The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practices on request.

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

Relationship: \_\_\_\_\_

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

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I was unable to obtain the patients signature

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