Notice of Privacy Practices

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 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 is used. HIPAA provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations:

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers (i.e. implants)
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing and/or collection activities, and utilization review (i.e. submitting claim forms to insurance).
- **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 (i.e. internal quality assessment review)

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

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 acted relying on your authorization.

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

I have read and understand my rights about HIPAA. Any questions I may have had have been answered to my satisfaction.

_____ _____

Patient/Parent/Guardian Signature Date

HIPPA Right of Access Form

Release of Information

I, _____, authorize the release of information pertaining to and including appointments, diagnosis, treatment, and account information to the following:

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This release of information will remain in effect until terminated by me in writing.

Messages

If you are unable to each me, Fayette Family Dental may leave a detailed message

[ ] on my cell phone at _____

[ ] on my home phone at _____

[ ] via email at _____

[ ] DO NOT leave a detailed message, simply ask for a return call.

_____ _____

Patient/Parent/Guardian Signature Date