



## NOTICE OF PRIVACY PRACTICES

We understand that your medical and dental information is personal and we are committed to protecting it. We create a record of the care and services at our office. We need this record to provide you with quality dental care and to comply with certain legal requirements. This notice will tell you about the way we may use and share your Protected Health Information (PHI).

**Patient Rights:** You have the right to request a copy of your health records and to request the type of format you want (paper or electronic). If you request, in writing, that a copy of your records be sent to a specific third party, the records will be sent as directed in a timely manner.

**We have a legal duty to:**

1. Keep your personal health information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.
4. Notify you of an accidental disclosure of your private health information in a timely manner.

**We have the right to:**

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

**Notice of change to privacy practices:**

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following describes different ways that we use and disclose your medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose dental/medical information. We will not use or disclose your dental/medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

1. **For treatment:** We may use your PHI to provide you with dental treatment or services. We may disclose dental/medical information about you to healthcare providers who may be involved in your treatment both directly and indirectly.
2. **For payment:** We may use and disclose your PHI for payment purposes. A bill may be sent to you or a third-party payer or collection agency. The information on or accompanying the bill may include dental/medical information.
3. **For health care operations:** We may use and disclose your PHI for our health care operations including quality assessments, evaluating the performance of employees and conducting training.
4. Prettyman Orthodontics may not sell or use your PHI for marketing or fundraising purposes without your signed authorization.
5. If you pay for your dental treatment and request that we disclose the procedure to your insurance company, we must comply with your request as long as you pay in full for the procedure in a timely manner.

**I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing this 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.**

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_

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