Notice of Privacy Practices

- I understand my health care information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance and in communicating with other health care professionals in the course of my treatment or their offices. Radiographs and communication regarding my treatment and care may be sent via e-mail. I understand e-mail is not secure and could be intercepted by someone without authorization. Limited information will also be disclosed to businesses supporting the operations of this office, such as dental or medical labs, hospitals, accountants, computer support, billing personnel, answering services and consultants. These businesses are restricted in the use and disclosure of my information by contract. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for my health care with my knowledge, you may disclose information to that family member or person.

- I understand my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should occur.

- I understand I have the right to access, copy or inspect and correct my health care information, the right to restrict disclosures and obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory act by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure at anytime by written notice to Carefree Dentists, except to the extent that the disclosure authorized has already been acted upon prior to receipt of revocation. A minimal fee of $0.20 per page will be charged to me for copies of records that I request.

- I understand I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the form of fax, e-mails or other electronic means. I understand if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home, cell or work voicemail.

I have read and understand this office policy. I understand by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims and healthcare operations. This office retains the right to revise the privacy policy.

_____	_____	_____
Patient or Guardian's Signature	Printed Name	Date

☐ I have read this form and do not wish to sign. _____ (Please initial)

☐ Please list on reverse side the names of people who may have access to your health information. Include their relationship to you as well as phone and email if available.