Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can have access to this information. Please review the following carefully.

To Provide Treatment: We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment: We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with the companies with a similar commitment to the security of your health information.

In Patient Reminders: Because we believe regular care is very important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest of you. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters or telephone reminders.

Abuse or Neglect: We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security: We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control of prevention of an epidemic or the understanding of new side affects of a drug treatment or medical device.

For Law Enforcement: As permitted by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes; including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers: We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payments. We will be sure to ask you permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use of Disclose Health Information: Other than what is state above, or where Federal, State or Local law requires us, we will not disclose your health information other that with your written authorization. You may revoke that authorization in writing at any time.

(OVER)

Patient Rights

The law is careful to describe that you have the following rights related to your health information.

Restrictions: *You have the right* to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications: *You have the right* to request that we communicate with you in a certain way. You may request that we only communicate health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information: *You have the right* to read, review and copy your health information including your complete chart, x-rays and billing records. If you would like a copy of your information, please let us know. *We do require a 48hour notice. We may charge you a reasonable fee to duplicate and assemble your copy.*

Amend Your Health Information: *You have the right* to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains the information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information recorded in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information: *You have the right* to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14th, 2003 and forward. Please let us know in writing the time period in which you are interested. Thank you for limiting your request to know more than 6 years at a time. We may need to charge you a reasonable fee for your request.

Request Paper Copy of This Notice: *You have the right* to obtain a copy of this *Notice of Privacy Practices* directly from our office at any time. You may stop by our office or call us and we will mail a copy to you. We are required by law to obtain the privacy of your health information and to provide to you and your representative the notice but we reserve the right to change the terms of our *Notice of Privacy Practices*. If we change our *Privacy Practices* we will be sure all of our patients receive notice. *You have the right* to express complaints to us or to Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your complaints in writing.

Patient Acknowledgement

I acknowledge that I have received the Dr. Rita J. Tamulis-Shea, D.D.S., Ltd., Notice of Privacy Practices.

____
Print Patient Name

____	______________________________
Patient Signature or Signature of Patient's Parent/Guardian	Date
____	______________________________
Print Name of Parent/Guardian	If Guardian, please describe relationship to patient