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## **Autauga Station Dental**

### **NOTICE OF PRIVACY PRACTICES**

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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#### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (MM/DD/YR), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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#### **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**Autauga Station Dental  
Dr. Brock C. Miller**

**Health Insurance Portability & Accountability Act (HIPAA)  
Medical Information Release**

Due to FEDERAL PRIVACY GUIDELINES UNDER HIPAA (Required April 2003) we are required to have a medical release of information on file for each patient. This authorizes our office to release medical information to your designated family members, caregivers, and friends, as well as, pharmacists, hospitals, emergency medical personnel, and referral specialists about you or your minor (under 14 years of age) children's PROTECTED HEALTH INFORMATION (PHI). Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, telephone, answering machine, fax, mail or e-mail as needed for your care to only those you have identified below. By your signature below, you also acknowledge that you have received the Notice of Privacy Practices from Autauga Station Dental.

To carry out any request for PHI, we must have a list of names, date of birth and phone numbers of the authorized individuals below. Do Not list anyone who has not agreed to provide us with valid identification.

**\*\*Please Print**

I, \_\_\_\_\_ (patient or child's name) DOB \_\_\_\_\_ hereby authorize the following individual(s) listed below to discuss my dental/medical care with you and your staff on my behalf.

Names	DOB	Phone#
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any health information you do not wish to be given out, please list below:

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The above information is private and confidential and will be placed in your dental record.

Signature \_\_\_\_\_ Relation \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

DISCLAIMER (Check below only if you want NO ONE ELSE to have access to information.)

\_\_\_\_\_ I DO NOT want you to discuss my dental/medical care with anyone other than myself.