HIGHLAND HEIGHTS Dental

NOTICE OF PRIVACY PRACTICES

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.

OUR PLEDGE TO PROTECT YOUR PRIVACY

We are dedicated to protecting your health information while providing you with the highest quality dental care.

This notice explains how we may use and disclose your health information and describes your rights and our obligations regarding the use and disclosure of your health information. We are required by law to give you this notice.

We must follow the privacy practices and the terms of this notice at any time. 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 our office manager.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We are permitted to use and disclose your health information for treatment, payment, and healthcare operations.

For example:

Treatment: We are permitted to use or disclose your health information as necessary to provide you with treatment and may disclose you health information to another healthcare provider providing treatment to you.

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

Healthcare Operations: We are permitted to use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, evaluating 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 are permitted to 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. If you do not want us to make these disclosures, please contact our office manager.

Persons Involved in Care: We are permitted to 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 an opportunity to object to such used 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.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to receive communications about treatment alternatives or health-related products and services.

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

Abuse or Neglect: We are permitted to 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 are permitted to 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.

National Security: We are permitted to disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We are permitted to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We are permitted to disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We are permitted to use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

YOUR RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may obtain a form to request access by contacting our office manager. There may be a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last two years, but not before March of 2009.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you would like more information about your privacy practices or have questions or concerns, please contact our office manager:

4046 Highland Drive, Suite 115
Salt Lake City, Utah 84124
(801) 424-3500

If you are concerned that we may have violated your privacy rights, you may complain to us by contacting our office manager. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HIGHLAND HEIGHTS Dental

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected information about you. By signing this form, you consent to our use and disclosure of protected health information about you for Treatment, Payment and Healthcare Operations. You have the right to revoke this consent in writing.

I have received a copy of the *Notice of Privacy Practices* for Highland Heights Dental, and hereby give consent for Highland Heights Dental, to use my personal health information for Treatment, Payment, and Healthcare Operations.

Patient's Name (please print):_____

Signature: _____ Date:_____

If this is signed by a personal representative on behalf of the patent, complete the following:
Personal representative's Name: _____

Relationship to Patient: _____