Harris Family Dental S.C.

NOTICE OF PRIVACY PRACTICES

Effective Jan 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Legal Duties

We are required by law to maintain the privacy of your protected health information (PHI). We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Information. We are also required to give you this Notice about our privacy policies, our legal duties, and your rights regarding your PHI. We must follow the privacy practices listed in this Notice while it is in effect. We may change our privacy practices at any time, provided that those changes are legally permitted. If we change the terms of this Notice, we will issue a new Notice and the new Notice shall be effective for all PHI that we maintain. We will post any new Notice in our office and make copies available upon request. The effective date of our Notice is listed above. 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 the Privacy Officer listed below.

Uses and Disclosures of PHI

We may use and disclose your PHI for treatment, payment and healthcare operations as follows:

TREATMENT: We may use your PHI and share It with other professionals who are treating you. For example, we may share your PHI with another health care professional whom we may refer you to or who is also currently treating you.

PAYMENT: We may disclose your PHI to obtain payments for services that we have provided for you. For example, we may disclose part of your PHI to the billing department of your insurance company, a collection agency, attorneys, or others who may be responsible for paying your bill in order to collect payment for services rendered.

HEALTHCARE OPERATIONS: We may use your PHI for our healthcare operations. Examples of this would include evaluating provider performance, conducting training procedures, accreditation, or for credentialing activities.

We are also allowed or required to share your information in other ways. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. These include:

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES: We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

RESEARCH: We can use or share your information for health research.

COMPLY WITH THE LAW: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS: We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS: We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

RESPOND TO LAWSUITS AND LEGAL ACTIONS: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Finally, in some instances we may use or disclose your PHI only with your written authorization. These include:

TO OTHER PERSONS INVOLVED IN YOUR HEALTHCARE: We may share your PHI with a family member or other person identified by you, if that PHI is directly related to that person's involvement in your care, payment for your care, or to notify them of your general condition after care. We may only do so if you agree to such disclosure or, if you are unable to tell us your preference (for example, if you are unconscious), if we believe based on our professional judgment that you would not object to this disclosure.

MARKETING: We may not share your information for marketing purposes without your authorization.

SALE OF YOUR INFORMATION: We may not sell your PHI without your written authorization.

ALL OTHER USES AND DISCLOSURES: We cannot use or disclose your PHI for any reason other than as described in this Notice without your written authorization. You may give us this authorization to use your PHI to anyone and for any purpose, and you may revoke this authorization at any time. Such revocation shall not affect any uses or disclosures which have already been made prior to the revocation.

Patient Rights

RIGHT TO ACCOUNTING AND DISCLOSURES OF YOUR PHI: You have a right to receive a list of instances in which we disclosed your PHI for purposes other than health care operations, treatment and payment, and other certain activities for the last 6 years. You must submit your request in writing to the Privacy Officer and sign and date the request.

RIGHT TO SEE AND COPY YOUR HEALTH INFORMATION: You have the right to see your PHI and to get copies of your health information, with limited exceptions. You must make a request for your PHI in writing. This request must be signed and dated.

RIGHT TO REQUEST RESTRICTION: You have the right to request that we place additional restrictions on the use of your PHI including all of the uses listed above. You must submit your request in writing to the Privacy Officer and sign and date the request. We are not required to agree to these restrictions, but if we do, we will abide by our agreement except in situations such as providing emergency treatment.

RIGHT TO REQUEST ALTERNATIVE COMMUNICATION: We may contact you via phone, email, mail, or text messaging, and may leave messages on the phone number that you supply to us, pursuant to the consent to electronic communications that you give us. However, you have the right to request that we communicate with you about your PHI by alternative means. This request must be made in writing to the Privacy Officer and it must be signed and dated. The request must specifically ask for the ways in which you would like to be contacted. You do not have to indicate the reason for why you wish to have this done.

RIGHT TO REQUEST AMENDMENT: You have the right to request that we amend your PHI. This request must be submitted in writing to the Privacy Officer, signed and dated. You must explain why the PHI should be amended.

REQUEST A PAPER COPY OF THIS NOTICE: You have the right to request a paper copy of this Notice from us at any time. Please contact the office you received services or treatment from to request a paper copy.

QUESTIONS AND COMPLAINTS: If you have any further questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed below. You may also submit a written complain to the U.S. Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We support your right to the privacy of your PHI and will not retaliate against you for filing a complaint.

PRIVACY OFFICER CONTACT INFORMATION:

Privacy Officer
2600 N Mayfair Rd
Suite 690
Wauwatosa, WI 53226
(414) 771-1228

Harris Family Dental S.C.

ACKNOWLEDGEMENT OF RECEPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____ , have reviewed a copy of this office's Notice of Privacy Practices.
(print guardian, or patient name if 18yrs or older)

I understand a copy is available to take home if requested.

_____
(Please Print Patient Name)

_____
(Guardian or Patient Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify) _____

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