



500 Federal St. • Suite 600 • Troy, NY 12180 • phone: (518) 274-4322

PRIVACY NOTICE

This notice is required by the New Patient Privacy Regulation issued by the United States Department of Health and Human Services (AHHS@), and describes how your medical information may be used or disclosed, and how you may gain access to your medical information.

Your Protected Health Information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you;
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account;
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification licensure or accreditation;
- Internally, to all staff members who have any role in your treatment; and/or
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your Protected Health Information;
- Request confidential communication of your Protected Health Information;
- Inspect and obtain copies of your Protected Health Information through asking us;
- Amend or modify your Protected Health Information;
- Receive an accounting of certain disclosures made by us of your Protected Health Information; and
- You may file a complaint with the HHS Secretary as to any violation by us of your privacy rights, which must be filed within 180 days of the violation.

We have the following duties under the privacy rules:

- To only utilize your Protected Health Information as set forth in the attached Consent and/or Authorization;
- To obtain your written consent to use your protected patient information for treatment, payment or health care operations, and to refuse treatment if you refuse to sign the consent;
- To obtain your written authorization to use your protected patient information for any purposes other than treatment, payment or health care operations;
- To use reasonable efforts to limit the amount of Protected Health Information that is used, disclosed or requested to the minimum degree necessary where such information is used, disclosed or requested for the purposes other than treatment; and
- To obtain satisfactory assurances from our business associates who render services to our office that your Protected Health Information will be safeguarded by them.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your Protected Health Information;
- Amend your Protected Health Information, if, for example, it is accurate and complete; or
- Provide an atmosphere that is totally free of the possibility that your Protected Health Information may be overheard by other patients and third parties.

If you have any questions about the information in this notice, please let us know. Thank you.

PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your Protected Health Information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's Privacy Notice prior to signing this Consent, a copy of which was given to you with this Consent.

You have the right to request restrictions on the use of your Protected Health Information, however, we are not required to, and may not honor your request.

We may amend the attached Privacy Notice at any time. If we do, we will provide you with a copy of the changes, and the changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing, however, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient

Date

Parent/Guardian Signature

Relationship to Patient

Witness Signature

Date