Office of West SoHo Dentistry

Introduction to Privacy Notice

Dear Patient,

This is a summary of the ways in which medical information about you may be used and disclosed, and how you can get access to this information. Dr. Huang and her entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by the health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal and state law.

The complete Notice of Privacy Practices is attached. **We encourage you to read the entire Notice.** You are required to acknowledge in writing that you have received a copy of the Notice.

The attached Notice is effective as of April 14, 2003.

Office of West SoHo Dentistry

Notice of Privacy Practices for Protected Health Information

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.

Dr. Huang and her staff (collectively, "the Practice") are dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information. This notice applies to all of the records of your care generated by the Practice, **[whether made at this office or at any of our facilities in other locations]**. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic. If the Practice revises the terms of this notice, it will post a revised notice in this office **[and at all its facilities]** and will make paper copies of this Notice of Privacy Practices for Protected Health Information available upon request **[, as well as update its website]**.

How Your Medical Information Will Be Used and Disclosed:

The Practice will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. As to treatment, we may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, and other personnel of the Practice involved in taking care of you. We may also disclose medical information about you to people outside the Practice who may be involved in your medical care. As to payment, we may use and disclose medical information about you so that the treatment and services you receive at the Practice, **[whether here or at another of our facilities]**, may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a procedure you underwent here so that your health plan will pay us or reimburse you for the procedure.

As to health care operations, we may use and disclose medical information about you for operations at the Practice. These uses and disclosures are necessary to run the facilities of the Practice, and to make sure that all our patients receive quality care.

The Practice may also use and/or disclose your medical information in accordance with federal and state laws for the following purposes:

♦To contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

♦When required by the U.S. Department of Health and Human Services as part of an investigation or determination of compliance by the Practice with relevant laws.

♦Unless you object, the Practice may disclose to family members, other relatives, or close personal friends the medical information directly relevant to such person's involvement with your care. The Practice may also give relevant information to an individual who helps pay for your care.

♦To a public or private entity for the purpose of coordinating with that entity to assist in disaster relief efforts.

♦For public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention, or to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, and administrative and/or legal proceedings.

♦If you are involved in a lawsuit, claim, potential claim, or dispute, we may disclose medical information about you to attorneys, investigators, insurance companies, and related entities representing the interests of or insuring the doctors and/or other personnel affiliated with the Practice. We may also disclose medical information about you in response to a court or administrative order. We may also disclose

medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

♦For federal, state, or local law enforcement purposes, or other specialized governmental functions, as follows: 1) in response to a court order, subpoena, warrant, summons, or similar process; 2) to identify or locate a suspect, fugitive, material witness, or missing person; 3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; 4) about a death we believe may be the result of criminal conduct; 5) about criminal conduct at this **[or another of our facilities]**; and 6) in emergency circumstances, to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

♦To a coroner, medical examiner, or a funeral director.

♦To an organ donation and procurement organization, if you are an organ donor.

♦For certain research purposes, if the project has been reviewed and approved through a process which balances the research needs with patient privacy interests. We will ask for your consent to participate in any research study, when applicable.

♦To prevent or lessen a serious threat to the health or safety of another person or the public. Any disclosure, however, would only be to someone able to prevent the threat.

♦As authorized by laws relating to workers' compensation or similar programs.

♦As required by domestic or foreign military command authorities, if you are a member of the armed forces of the United States or a foreign country.

♦As authorized by laws relating to intelligence, counterintelligence, and other national security activities.

♦To authorized federal officials for the protection of the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

♦To obtain payment for health care services that we provide to you. This may include disclosures to your health insurance plan, and disclosures to third parties with respect to payment to such party.

The Practice will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. However, we are unable to take back any disclosures we have already made with your permission. We are required to retain our records of health care services we provide to you.

Your Rights Regarding Your Medical Information:

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Such information is contained in a designated record set for as long as we maintain the medical information. A "designated record set" contains medical and billing records and any other records used to make decisions about your treatment. Usually, this does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to this office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. To request an amendment, your request must be made in writing and submitted to this office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

♦Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

♦Is not part of the medical information kept by or for the Practice; or

♦Is not part of the information which you would be permitted to inspect and copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of medical information about you. However, you are not entitled to any disclosures made: 1) related to treatment, payment, or health care operations of the Practice, 2) to you, 3) to persons involved in your care or as otherwise permitted above, 4) pursuant to an authorization, 5) for national security or intelligence purposes, 6) to correctional institutions or law enforcement officials, 7) as part of a limited data set, or 8) prior to April 14, 2003.

To request this list or accounting of disclosures, you must submit your request in writing to this office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you a fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, or as otherwise permitted by law.

To request restrictions, you must make your request in writing to this office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

Right to Request Alternative Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request alternative communications, you may obtain a form for that purpose, upon presentation of valid identification, at the Practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. **[Even if you have received this notice from our website, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, (uppereastidebraces.com.]**

To obtain a paper copy of this notice, you must make your request in writing to this office.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with this Practice and/or the Secretary of the Department of Health and Human Services. To file a complaint with this Practice, simply leave the written complaint with our receptionist. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other Uses of Medical Information:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003.

PATIENT MUST SIGN ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE.

PATIENT ACKNOWLEDGMENT
OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

Dated: _____ ___, 2017

New York, New York

_____

Signature of Patient or Representative

Patient's Name (Printed):_____

Name of Personal Representative:_____
(Printed) (If Applicable)

Relationship to Patient:_____
(If Applicable)