

Paul B. Lederman, DDS
Lederman and Lederman, DDS

14575 Bel-Red Road #101
Bellevue, WA 98007
(425) 746-6020
www.drlederman.net

Notice of Privacy Practices

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.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This Federal law gives you, the patient, significant new right to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment** means providing, coordinating or managing health care and related services by one or more health providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilizing review. For example, we disclose treatment information when billing a dental plan for your dental service.
- Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless your request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare it with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relating on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of **April 14, 2003** and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with is at the address below, or with the Department of Health Services, Office of Civil Records, in the event you fell privacy right have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Paul Lederman, DDS
Lederman and Lederman, DDS
14575 Bel-Red Road, Suite #101
Bellevue, WA 98077

p: (425) 746-6020
f: (425) 401-5118
www.drlederman.net

For more information about HIPAA or to file a complaint:

The U.S Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201

Toll Free: (877) 696-6775

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to :

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payer for my health care services.
- Conduct normal health care operation such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or health care operations, and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient's Name: _____ **Date:** _____

Patient's Signature: _____

Relationship to Patient: _____

Dependent (s) family members also covered by this acknowledgement: _____

Additional Disclosure Authority

- Any member of my immediate family _____ Your Signature
- Spouse only: _____ Their Name/Your Signature
- Other-SPECIFY: _____ Their Name/Your Signature

For Office Use Only:

We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency Situation
- Other: _____

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