

# 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!**

With your consent, the practice is permitted by federal laws to make uses of your health information for purposes of treatment, payment, and health care operations.

## **Your Health Information Rights**

Your health and billing records are the property of the practice; the information in it, however, belongs to you. With a written request delivered to our office, you may:

- Request a restriction on certain uses and disclosures of your health information.
- Inspect and copy your health record and billing record.
- Appeal a denial of access to your protected health information;
- Request that your record be amended to correct incomplete or incorrect information; if denied, you may also file a statement of disagreement and require that the amendment request and any denial be attached in all future disclosures;
- Obtain an accounting of disclosures of your health information as required to be maintained by law. An accounting will not include internal uses of information, disclosures made to you or made at your request, or disclosures made to family members or friends.
- Request that communication of your health information be made by alternative means or at an alternative location.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation.

## **Our Responsibilities**

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

## **To Request Information or File a Complaint**

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Fisher Dental 541-269-2100**. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office. You may also mail a complaint to: **Secretary of Health and Human Services, 200 Independence Avenue S.W., Washington, D.C. 20201**.

## **Authorized Contact**

In addition to use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use or disclose your health information to anyone for any purpose. If you do not give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. You may revoke your authorization in writing at any time.

- Authorized Person: \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)
- Authorized Person: \_\_\_\_\_ (name) \_\_\_\_\_ (relationship)

## **Other Disclosures and Uses**

With your consent or as directed by a proper court order, other disclosures and uses of your health information may include: mandated reports to the Food and Drug Administration (FDA), proceeding in worker's compensation claims, requests by public health agencies, law enforcement agencies, and in judicial or administrative proceedings.

Effective Date: May 17, 2012

I, \_\_\_\_\_, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date