# ALBANY GROUP DENTAL PRACTICE, P.L.L.C.

## NOTICE OF PRIVACY PRACTICES

**This Notice describes how Dental/Medical information about you may be used and disclosed and how you can get access to this information.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT. You will be asked by your dentist to sign a consent/acknowledgment form. By signing this form, our dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your PHI (protected health information) to pay your health care bills and to support the operation of the dentist's office. Following are examples of the types of uses and disclosures of your protected health care information that the dentist's office is permitted to make once you have signed our consent/acknowledgment form.

**Treatment:** We will use and disclose our protected health information to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party that has already obtained your permission to have access to your protected health information.

**Payment:** Your protected dental information will be used, as needed, to obtain payment for our dental services. This may include certain activities that your dental insurance plan may undertake before it approves or pays for the dental care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use of disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure to your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use of disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use of disclosure of all or part or your protected health information. If you are not present or able to agree or object to the use of disclosure of the protected health information, then your dentist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health formation that is relevant to your health care will be disclosed.

**Others Involved in your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your dental care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interested based on our professional judgment. We may use of disclose protected health information to notify or assist in

notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If his happens, your dentist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your dentist or another dentist in the practice is required by law to treat you, and the dentist has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your dentist or another dentist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the dentist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

**We may use or disclose your protected health information I the following situations without your consent or authorizations:**

**When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse of Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement Coroners, Funeral Directors, Organ Donation, Criminal Activity, Military Activity and Inmates and National Security.**

**Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

**You have the right to inspect and copy your protected health information.**

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, or payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your dentist is not required to agree to a restriction that you requested. If the dentist believes it is in your best interest to permit use and disclosure of our protected health information, your protected health information will not be restricted. If your dentist does agree to the requested restriction, we may no use or disclose your protected health information I violation of that restriction unless it is needed to provide emergency treatment.

You have the right to request to receive confidential communications from us by alternative means or at any alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your dentist amend you protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

If you have any questions or would like further information about this Notice, you can contact our Privacy Official at:

**Tina Grant**
**1575 Central Ave.**
**Albany, NY 12205**
**518/869-7167**
**518/869-7182 (fax)**
**tgrant1031@nycap.rr.com**

**THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR AFTER MAY 9,2007. THIS NOTICE WAS UPDATE JUNE 4, 2015**

# ALBANY GROUP DENTAL PRACTICE, P.L.L.C.

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

- ✓ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

**Patient Consent Form/Notice of Privacy Practices Acknowledgement**

**I have been informed by you, and I acknowledge that I have received** your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. **I have been given the right to review** such *Notice of Privacy Practices* prior to signing this consent. **I understand that this organization has the right to change** its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke my consent I writing at any time, except to the extent that you have taken action relying on my consent.

**Patient Name _____ Date_____**

**Relationship to Patient _____ Signature _____**

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date_____Initials_____Reason_____