

## AMERICAN ASSOCIATION OF ORTHODONTISTS HIPAA FORM

### NOTICE OF PRIVACY PRACTICES FOR COLUMBIA TOWN CENTER ORTHODONTICS

5570 Sterrett Place, Ste 301 Columbia, MD 21044

**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.**

#### **UNDERSTANDING YOUR HEALTH INFORMATION**

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law. This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

#### **How We Will Use or Disclose Your Health Information**

**Treatment:** We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations, so the physician will know how you are responding to treatment. We will also provide your physician, or a subsequent healthcare provider, with copies of various reports that should assist him or her in treating you.

**Payment:** We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

**Health Care Operations:** We will use your health information for our regular health care operations. For example, we may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in a continued effort to improve the quality and effectiveness of the services we provide.

**Business Associates:** We may enter into contracts with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

**Notification:** We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

**Communication with Family:** We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

**Appointment Reminders / Health Benefits:** We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

**Workers' Compensation:** We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law. **Public Health Activities:** As required by law, we may disclose your health information to public health, or legal authorities, charged with preventing or controlling disease, injury or disability.

**Health Oversight Activities:** We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

**Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution, or agents thereof, health information necessary for your health and the health and safety of other individuals.

**Judicial and Administrative Proceedings:** We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

**Law Enforcement Purposes / Serious Threat to Health or Safety:** We may disclose your health information to enforcement officials for law enforcement purposes under certain circumstances and subject to certain conditions. We may also disclose your health information to prevent or lessen a serious and imminent threat to a person or the public (when the disclosure is made to someone we believe can prevent or lessen the threat) or to identify or apprehend an escapee or violent criminal.

**Victims of Abuse, Neglect and Domestic Violence:** In certain circumstances, we may disclose your health information to appropriate government authorities if there are allegations of abuse, neglect or domestic violence.

**Essential Government Functions:** We may disclose your health information for certain essential government functions (e.g., military activity and for national security purposes).

The following uses and disclosures will be made only with your authorization:

- (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications;
- (ii) disclosures that constitute a sale of your health information; and
- (iii) other uses and disclosures not described in this notice

You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

## **Your Health Information Rights**

Although your health record is the physical property of this office, you have following rights with respect to your health information. You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us.

Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.

- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.
- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.
- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.
- You may request that we provide you with a written accounting of all disclosures made by us during the time period for which you request (not to exceed six years), as required by law. We ask that such requests be made in writing on a form provided by us. Please note that accounting does not include all disclosures, e.g., disclosures to carry out treatment, payment, or healthcare operations and disclosures made to you or your legal representative or pursuant to an authorization. You will not be charged for your first accounting request in any 12-month period. However, for any requests that you make thereafter, you will be charged a reasonable, cost-based fee.
- You have the right to be notified following a breach of your unsecured protected health information.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

## **For More Information or to Report a Problem**

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows:

**COLUMBIA TOWN CENTER ORTHODONTICS**  
**5570 Sterrett Place, Ste 301 Columbia, MD 21044**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: **COLUMBIA TOWN CENTER ORTHODONTICS 5570 Sterrett Place, Ste 301 Columbia, MD 21044**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices and had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT