Sea Country Dental

Acknowledgement of Receipt of

HIPAA Notice of Privacy Practices

32341 Golden Lantern, Suite C, Laguna Niguel, CA 92677 • 949.496.7910 • Fax 949.496.3778

This form acknowledges your receipt of the HipAA Notice of Privacy Practices, or our good faith effort to obtain that acknowledgement. (Please Print)

PATIENT'S LAST NAME _____

FIRST NAME _____

Sea Country Dental Hipaa Notice of Privacy Practices

This notice describes how protected health information about youmay be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your protected health information is important to us.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We ust follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until replaced. You may request a copy of out Notice at any time. For more information about our privacy practics, or for additional copies of this Notice, plase contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose protected health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your protected health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use or disclose your protected health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: Our dental facility employs an open system of delivering dental care. We will make every reasonable attempt to avoid accidental disclosure of your protected health information. Should you have any concerns, please advise us and we will attempt to acoommodate you. We may use or disclose, as needed, your protected health information in order to support our business activities. For example, we may use a sign-in sheet at the reception desk where you will be asked to sign in. We may call you by name in the reception room when the doctor is ready to see you, and he may have a copy of that day's schedule with your name on it in his operatory. We may use or disclose your protected health information, as needed to contact you by phone, e-mail, or mail, to confirm your dental appointment. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, etc.) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information. We may use or disclose your protected health information, as necessary, to send you a newsletter or information regarding other services we might offer. We may also send you information about products or services we feel might be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

YOUR AUTHORIZATION: We will obtain your written authorization should we need to use or disclose your protected health information outside of our third party associates.

TO YOUR FAMILY AND FRIENDS: We must disclose your protected health information to you, as described in the Patient Rights section of this Notice. We may disclose your protected health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN YOUR CARE: We may use or disclose your protected health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, your location, your general condition, or your death. If you are present, prior to use or disclosure of your protected health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose your protected health information based on a determination using our professional judgement, disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms or your protected health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your protected health information for marketing comunications without your written authorization.

REQUIRED BY LAW: We may use or disclose your protected health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your protected health information to appropriate authorities if we reasonably believe your protected health information to the extent necessary to avert a serious threat to our health or safety, or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities, the protected health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials protected health information required by lawful intelligence, counterintelligence, and othe national security activities. We may disclose protected health information or an inmate or patient under certain circumstances.

PATIENT RIGHTS:

ACCESS: You have the right to look at or obtain copies of your protected health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make your request in writting. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based free for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $10.00 without x-rays, and $20.00 if x-rays are requested. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your protected health information for purposes other than: treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not prior to April 14, 2003. If you request this additional restrictions, however, if we do, we will abide by our agreement (except in an emergency).

RESTRICTION: You have the right to request that we place addtional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, however, if we do, we will abide by our agreement (except in any emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your protected health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your protected health information. Your request must be in writing, and must explain why the information should be amended. We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our website, or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, or in response to a request you made to amend or restrict the use or disclosure of your protected health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

Privacy Contact: Gina Martin

Phone: (949) 496-7910

For Office Use Only Below This Line

Please specify the reason the patient chose not to sign the acknowledgment of receipt of the HIPAA Notice of Privacy Practices.

❑ Patient / Parent or Legal Representative received the HIPAA Notice of Privacy Practices but refused to sign the acknowledgment of Receipt.

❑ Patient/Parent or Legal Representative unavailable to acknowledge receipt of the HIPAA Notice of Privacy Practices.

Staff Signature:_____ Date:_____

If you would like a copy of this notice for your records, please inform our staff.

Rev. 3/13

X _____ Date_____

Patient/Parent's Signature:

_____ Date_____

Patient Representative's Signature: