Santa Fe Dental Associates, L. L. P.

HIPAA Notice of Privacy Practices Form

Patient Name: _____
Date of Birth: _____
Today's Date: _____

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.
Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. 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 physician. We may also call you by name in the waiting room when your physician is ready to see you. **We may use or disclose your protected health information, as necessary, to provide you with appointment reminders (such as phone calls, voicemail messages, postcards, text messages, emails and letter correspondence.)** We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, communicable diseases: health oversight: abuse or neglect: Food and Drug Administration requirements: Legal proceedings: Law enforcement: Coroners: Funeral directors: Organ donation: Research: Criminal activity: Military activity: National security: Workers' Compensation: Inmates: 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 with the requirements of Section 164.500.
Friend, family and personal representatives:
Our office will use and disclose the minimum necessary amount of your PHI that is directly relevant to the involvement of a family member, other relative, a close personal friend or someone else identified by you. Involvement could be in relation to care or payment for services. Our office also will use and disclose the minimum necessary amount of your PHI regarding your location, general condition or death to a family member, a personal representative of yours or another person responsible for your care. Such uses and disclosure will be made only with your permission if you are present, unless you are incapacitated or there is an emergency circumstance where our office must exercise professional judgment. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You're Rights:
Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to 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, payment, or 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 the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes, it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive the confidential communications from us by alternative means or at an alternative location.
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 alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. 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.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.

This notice was published and becomes effective on/or before **October 15, 2015**.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Consent to Receive Text Messages or Emails about Appointment Reminders, Treatment Plans or Surveys:
Patients in our practice may be contacted via email or text messaging reminding of an upcoming appointment or to schedule an appointment. Treatment plans will be sent via email at the patient's request. Patient surveys will be sent via email or text to see how the practice is doing.

Please initial below and circle your preferences:

_____I **consent** / **do not consent** to receive text messages from the practice on my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.
(**The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. Contact your carrier for pricing plans and details**)

_____I **consent**/**do not consent** to receive email messages from the practice at my email for appointment reminders, postcards, surveys, treatment plans and any correspondence you may request via email. I understand that this request to receive email messages will apply to all future appointments and correspondence unless I request a change in writing.

Disclosure to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of discussing finding, treatment options, financials and care decisions to the family members and others listed below.

Name 1:_____
Name 2:_____
Name 3:_____

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Patient Name: _____

Patient/Guardian or Patient's Representative Signature: _____Date:_____