

BAILEY FAMILY DENTAL & BRACES

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Dental Practice Covered by This Notice

This Notice describes the privacy practices of Bailey Family Dental & Braces (“Dental Practice”). “We” and “Our” means the Dental Practice. “You” and “Your” means our patient.

How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice:

Dental Practice Name:	Bailey Family Dental & Braces
Dental Practice mailing address:	308 Dartmouth Drive Midland, MI 48640
Dental Practice phone number:	(989) 631-6075

Information Covered by This Notice

This Notice applies to health information about you that we create or receive and that identifies you. This Notice tells you about the ways we may use and disclose your health information. It also describes your rights and certain obligations we have with respect to your health information. We are required by law to:

- maintain the privacy of your health information.
- give you this Notice of our legal duties and privacy practices with respect to that information.
- abide by the terms of our notice that are currently in effect.

Your Rights With Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our practice.

You have the right to receive, and we are required to provide you, a copy of this Notice of Privacy Practices. We are required to follow the terms of this Notice. We reserve the right to change the terms of our Notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and require a copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice and, if such is maintained by the practice, on its web site.

You have the right to authorize other use and disclosure. This means you have the right to authorize any use or disclosure of PHI (Protected Health Information) that is not specified within this Notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except

to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosures indicated in the authorization.

Confidential Communications: Alternative Means, Alternative Locations. This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone) and to a destination (i.e. cell phone number, alternative address) designated by you. You must inform us in writing using a form provided by our practice and how you wish to be contacted if other than the address/phone numbers that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of your complete health record. We have the right to charge a reasonable fee for copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI. This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information. This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request disclosure accountability. This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside our office.

You have the right to receive a privacy breach notice – You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required.

To Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our office. You may also file a written complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

The privacy of your health information is important to us. We will not retaliate against you in any way if you choose to file a complaint.

Our Use and Disclosure of Your Health Information Without Your Written Authorization

Common Reasons for Our Use and Disclosure of Patient Health Information

Treatment. We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

Health Care Operations. We may use and disclose health information about you in connection with health care organizations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

Special Notices. We may use or disclose your health information when contacting you to remind you of a dentist appointment. We may contact you by postcard, letter, voice mail or e-mail. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan to disclose information to the health plan sponsor. You have the right to opt out of such special notices, including receiving e-mails in response to questions about treatment, appointments, etc. Although we have placed every safeguard in place to secure your PHI on when transmitting e-mails, you can opt out of receiving e-mail communication from our practice. Please ask the Front Desk for the form to opt out of receiving e-mail communications.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

Disclosure to Family Members and Friends. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person that you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures. We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Your Written Authorization for Any Other Use or Disclosure of Your Health Information

We will make other uses and disclosures of health information not discussed in this Notice only with your written authorization. You may revoke that authorization at any time in writing. Upon receipt of the written revocation, we will stop using or disclosing your health information for the reasons covered by the authorization going forward.