

## Notice of Privacy Practices

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

### Our Legal Duty

Federal and state laws require us to maintain the privacy and your health information. We are also required to provide this notice about our office's privacy practices, our legal duties and your rights regarding your health information. We are required to follow the practices that our outlined in this notice while it is in effect. This notice takes effect 09/23/2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this notice, please contact us (contact information below).

### Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and health care operations. For example:

**TREATMENT:** We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other health care providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

**HEALTH CARE OPERATIONS:** We may use and disclose your health information in connection with our health care operations. Health care operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION:** In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**TO YOUR FAMILY AND FRIENDS:** We must disclose your health information to you, as described in the Patient Rights section of this notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends or any other identified by you.

**UNSECURED EMAIL:** We will not send you unsecured emails pertaining to your health information without prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

**PERSONS INVOLVED IN CARE:** We may use or disclose 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, of your location, your general condition or your death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgement and our 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 of health information.

**MARKETING HEALTH-RELATED SERVICES:** We may contact you about products or services related to your treatment, case management or care coordination or to propose treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relation to your care or if we refer you for health care. We will not otherwise disclose your health information marketing purposes with your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

**CHANGE OF OWNERSHIP:** If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

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

**PUBLIC HEALTH:** We may, and are sometimes legally obligated to, disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

**ABUSE OR NEGLECT:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**NATIONAL SECURITY:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**APPOINTMENT REMINDERS:** We may contact you to provide you with appointment reminders via voicemail, postcards or letters. We may also leave a message with the person answering the phone if you are not available.

**SIGN-IN SHEET AND ANNOUNCEMENT:** Upon arriving to our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

## **Patient Rights**

**ACCESS:** You have the right to look at or get copies of your 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 practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

**DISCLOSURE ACCOUNTING:** You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

**RESTRICTION:** You have the right to request that we communicate with you about your 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 and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**ALTERNATIVE COMMUNICATION:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify that alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

**BREACH NOTIFICATION:** In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

**AMENDMENT:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.)

## **Questions and Complaints**

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: Office Manager for Sidney D. Kelly, DMD

Telephone: 916-782-9479

Email: [info@kellyfamilydentist.com](mailto:info@kellyfamilydentist.com)

Address: 2360 Professional Drive, Suite 100, Roseville, CA 95661

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Sidney D. Kelly, DMD Family and Cosmetic Dentistry complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

**Acknowledgment of Receipt of Notice of Privacy Practices**

You may Refuse to Sign This Acknowledgement

**Patient Name:** \_\_\_\_\_  
Last First MI Preferred Name

**I authorize this dental practice to release any financial or dental information to the following person(s) listed below:**

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

**Personal Representative's name**

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

**For Program Use Only**

**We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other

**Response Date:** \_\_\_\_\_