



Notice of Privacy Practices (1 of 2)

This notice describes how health information about your child may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your child's protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We must be able to abide by the terms of this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make the Notice available upon request.

How We May Use and Disclose Your Child's Protected Health Information:

When we give you our Notice of Privacy Practices, you will be asked to sign an Acknowledgement of Receipt. Once you have received our Notice and signed the Acknowledgement, we will use your child's protected health information for treatment, payment and health care operations. We may use your child's protected health information in an emergency treatment situation. If this happens, we will try to obtain your signature on the Acknowledgement of Receipt as soon as is reasonable practical after the delivery of treatment. The following examples show the types of uses and disclosures of your child's protected health information that our office is permitted to make.

Treatment: Your child's protected health information may be used and disclosed by our office and others outside of our office that are involved in their dental care. We will use and disclose your child's protected health information to other dentists and physicians to provide, coordinate, consult, or manage their health care.

Payment: Your child's protected health information may be used and disclosed to pay their health care bills. Your child's protected health information will be used to obtain payment for the services we provide for them. This may include certain activities that your insurance plan may undertake before it approves or pays for the services we recommend.

Healthcare Operations: We may use or disclose your child's protected health information in order to support the business activities of our practice. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training and auditing/review activities. For example, we may call your child's name in the waiting room when the doctor is ready for them or send your postcards for appointment reminders. You may contact our Office Manager to request that these materials not be sent to you.

Business Associates: We may share your child's protected health information with the third party business associates that perform various activities for our practice. Whenever we disclose this protected health information to a business associate, we will have a written contract that will protect the privacy of your child's protected health information.

Written Authorization Is Required For Other Uses Of Your Child's Protected Health Information

Any other uses and disclosures of your child's protected health information will be made only with your written authorization, unless otherwise permitted by law. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your health information as provided in your authorization.

Use and Disclosure Permitted Without Authorization But With An Opportunity To Object

Family Members and Friends: Unless you object, we may disclose to your family member, a relative, a close friend, or any other person you select, your child's protected health information to the extent necessary to help with dental care or payment for the services we have provided. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up dental supplies, x-rays, prescriptions, or other similar forms of health information.



Notice of Privacy Practices (2 of 2)

Other Disclosures That May Be Made Without Your Authorization

Required By Law: We may use or disclose your child's protected health information when we are required to do so by law.

Abuse or Neglect: We may disclose your child's protected health information to appropriate authorities if we reasonably believe that if your child is a possible victim of abuse, neglect, or domestic violence. We may disclose to authorized officials' health information required to lawful intelligence, counterintelligence, and other national security activities.

Worker's Compensation & Health Oversight Activities: We may disclose your child's protected health information to comply with Worker's Compensation Laws and to health oversight agencies when conducting investigations or inspections as authorized by law.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required, to the Department of Health and Human Services when determining our compliance.

You Have The Following Rights

Inspect and Copy your Child's Protected Health Information: You have the right to look at or get copies of your child's 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 the request in writing to obtain access to your child's health information. You may obtain access by sending a letter to our Office Manager listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee.

Request a Restriction of Your Child's Protected Health Information: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Request Alternative Communications: You have the right to request that we communicate with you about your child's protected health information by alternative means or locations. You must make your request in writing. Your request must specify the alternative means or location, and provide a satisfactory explanation how payments will be handled under the alternative means or location you requested.

Request an Amendment to Your Child's Health Information: You have the right to request that we amend or correct your child's health information. This request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain circumstances.

Receive an Accounting of Disclosures We Have Made of your Child's Health Information: You have the right to an accounting of disclosures of your child's health information that occurred after this date. This accounting will be for purposes other than treatment, payment, or healthcare operations, or disclosures we have made to you, to family members, or friends involved in your child's care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee.

Make a Complaint About our Privacy Practices: If you are concerned that we have violated you or your child's privacy rights, you may file a complaint with our Office Manager using the contact information listed at the bottom of the page. You may also file a written complaint with the Department of Health and Human Services. We will provide you with the address upon request. We will not retaliate against you for making a complaint or change the way that we treat your child.

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 electronically.



Acknowledgement of Privacy Practices

I certify that I have received a copy of Justin A. Shuffer, DDS, INC's Notice of Privacy Practices.

Patient Name(s): _____

Parent/Guardian Name: _____

Signature: _____ Date: _____

Staff Will Complete This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our **Notice of Privacy Practices**.