# Notice of Privacy Practices

## Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. Our complete Privacy Practices are available for you to read. A copy is kept in our patient waiting room. You may choose to read that entire document before signing this consent form. We will not disclose your health information when we are not required to do so by law.

## Patient Rights

You have the right to look at or get copies of your health information, with limited exceptions. If you require copies of x-rays, there is a charge of $35 for this service. X-ray information will be provided in digital format on a floppy disk. We ask that you sign an additional consent form to have your records released. We may disclose appointment reminders to you via postcard or e-mail.

## Uses and Discloser of Health Information

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

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Healthcare Operations: We may sue and disclose your health information for treatment, payment or healthcare operations. These include staff meetings, quality assessments, evaluation of practitioner and provider performance, and conducting training programs.

Persons Involved In Care: In the case that you are incapacitated or there are emergency circumstances, we will disclose health information using our professional judgment to persons involved in your care. We will also use our judgment of your best interests in allowing such persons to pick up medical supplies, x-rays, or other health information.

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 of safety of others.

## Authorization

By signing this form, you will consent to our use and discloser of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Old South Dental. We may decline treatment if you revoke this consent. You are entitled to request a copy of this Consent.

Signature Patient/Guardian ______________________________________ Date ______________________