River City Dentistry, PC (Jason Allred, DMD)

rivercitydentistry.com rivercityoffice@gmail.com
737 N.Thornton St. Suite #A • Post Falls, ID 83854 (208)777-8668

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 privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices. 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. Such changes, and its new terms, will include health information we created or received prior to the changes. At such time, a new Notice will be made available.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for TREATMENT, for example, to another physician or other healthcare provider. For PAYMENT: to obtain payment for services we provide to you (for example to an insurance company). For HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations, including quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION

In addition to our use of your health information in the above cases, you may also give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was 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. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

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 death. If you are present, then prior to use or disclosure of your health information, we will privide you with an apportunity to object to such uses or disclosures, in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. 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 will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW

We may use or disclose your health information when we are required to do so by law.

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 of 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 activites. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS

We may use or disclose your health information to provide you with an appointment reminder (such as voicemail messages, postcards, or letters).

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 using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you .25 cents for each page, $10 per hour for staff time, to locate and copy your health information, and postage, if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation or your health information for a fee.

DISCLOSURE ACCOUNTING

You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 place additional restrictions on our use or disclosure of your 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).

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 the alternative means or location, and provide a satisactory explanation how payments will be handled under the alternative means or location you request.

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.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

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

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 a response to a request you made to amend or restrict the use or disclosure or your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us at the address and phone number listed below. You may also submit a written complain to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

River City Dentistry, PC

Address: 737 N Thornton St, Suite A
Post Falls, ID 83854
Telephone (208) 777-8668

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I,

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

have read a copy of the office's Notice of Privacy Practice. ◯ Yes ◯ No

You may refuse to sign this acknowledgement

Signature _____ **Date** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipts of out Notice of Privacy Practice, but could not be obtained because

◯ Individual refused to sign the acknowledgement

◯ An emergency situation prevented us from obtaining acknowledgement

◯ Communication barriers prohibited obtaining the acknowledgement

◯ Other (please specify):

Response Date: _____