

## PRIVACY POLICY/HIPAA

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 also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in 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, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the 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 a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BY PATIENT CONSENT

**TREATMENT:** We may use and disclose health information to a physician/dentist providing treatment to you.

**PAYMENT:** We may use and disclose health information to third party, insurance company to obtain benefit and prior approval for treatment or to justify medical care.

**HEALTHCARE OPERATIONS:** We may use and disclose your health information in connection with our healthcare operation. This includes quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluating practitioner and provider performance.

**YOUR AUTHORIZATION:** In addition to our use of your health information for treatment, payment or healthcare 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 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 is effect. Unless you give us 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 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 healthcare 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 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.

**MARKETIN 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, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your helath 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, and other national security activities. 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 appointment reminders (such as messages left with any person at given phone numbers, voicemail messages, postcards, email or letters)

**YOUR RIGHTS AS A PATIENT**

You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information.

You have the right to request an amendment to your medical records, by Charleston Dental Associates is not required by law to change your records.

You have the right to request an accounting of the disclosures Charleston Dental Associates has made.

You have the right to request restrictions or limitations on you healthcare 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.

You have the right to request confidential communications.

You have the right to obtain a copy of this notice at any time.

**For all requests, please note that Charleston Dental Associates has 30 days to respond to your request and has the right to charge you a copying fee.**

**QUESTIONS AND COMPLAINTS**

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

If you believe that your privacy rights have been violated, you may file a complaint with us using the contact information at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. 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.

**CONTACT OFFICER: Katie Letson 1875 Savage Road Charleston, SC 29407 843 766 0721**  
**info@charlestdentalassocites.com**

**CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

I AGREE TO TRUTHFULLY, COMPLETELY, AND CORRECTLY PROVIDE ALL REQUESTED INFORMATION TO CHARLESTON DENTAL ASSOCIATES. I AM GIVING CONSENT TO CHARLESTON DENTAL ASSOCIATES TO USE AND DISCLOSE MY HEALTHCARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

( this witness may accept consent verbally, by telephone, or email)