EFFECTIVE: September 20, 2013

OREGON ENDODONTIC GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I understand that Oregon Endodontic Group (referred to below as "the office") will use and disclose **health information** about me in the course of providing dental care to me.

I understand that my **health information** may include information both created and received by the office, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the office is permitted to **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to/or consult and coordinate with other dental/health care providers in the course of my treatment;
- Determine my eligibility for dental plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my dental care
- Perform various office, administrative, and business functions that support the office's ability to provide me with the appropriate care and arrange for payment.

I understand that uses and disclosures of private health information (PHI) for marketing purposes and disclosures that constitute a sale of PHI require and my written authorization. I understand my right to restrict certain disclosures of PHI to health plans if I pay out of pocket for the full cost of services at the time of service. I understand it is my right to be notified of a breach of unsecured PHI if I am affected by such of breach.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the office's Notice of Privacy Practices in effect will be posted in the office.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the office is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this office's Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)_____

See Reverse Side

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of home.

I wish to be contacted in the following manner: (check all that apply)

- ☐ Best Telephone:_____
  - ☐ O.K. to leave detailed message
  - ☐ Leave message with call-back number
- ☐ Work Telephone:_____
  - ☐ O.K. to leave detailed message
  - ☐ Leave message with call-back number
- ☐ Written/Oral Communication:
  - ☐ O.K. to mail to home address
  - ☐ O.K. to mail to work address
  - ☐ O.K. to fax to this number
  - ☐ O.K. to speak with spouse
- ☐ Other:_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birth Date

The privacy rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by an individual.

Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

FOR OFFICE USE ONLY
Record of Disclosure of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	1	Description of Disclosures/ Purpose of Disclosures	By Whom Disclosed	2	3

1 Check the box if the disclosure is authorized
2 Type Key: **T** – Treatment Records P – Payment Info O – Health Care Operations
3 Enter how disclosure was made: **F**-Fax **P**-Phone **E**-E-mail **M**-Mail **O**-Other

See Reverse Side