NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

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

Our Promise We will use and communicate your HEALTH INFORMATION purposes of providing your treatment, obtaining payment, conducting healthcare operations and as otherwise described in this notice.	**Notice of Privacy Practices** Federal law generally permits us to make certain uses or only for the disclosures of information without your permission. Law also requires us to list in the Notice each of these. The listing is below.
As Required By Law We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.	**Public Health & National Security** We may be required to disclose to Federal officials or military authority health information necessary to complete an investigation related to public health or national security.
For Law Enforcement As permitted or required by State or Federal law, we may disclose your health information to law enforcement officials if you are a victim of a crime or in order to report a crime.	**Family, Friends & Caregivers** We may share your health information with those you tell us will be helping with your treatment, medication or payment. We will ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgement when sharing your information.
Workers' Compensation Purposes We may disclose your information as required or permitted by State or Federal workers' compensation laws.	**Incidental Uses & Disclosures** We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.
Judicial & Administrative Proceedings We may disclose your information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.	**Health Oversight Activities** We may disclose your information to a government agency responsible for overseeing the health care system or health-related government benefit program.
To Avert a Serious Threat Health or Safety We may use or disclose your health information. To reduce a risk of serious and imminent harm to another person or to the public.	**Abuse or neglect** We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make this disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Your Information May be Used to Provide Treatment

- To Obtain Payment by way of insurance forms filed for you and through collections for payment of services rendered
- To Conduct Health Care Operations in which we have training for our staff and students
- In Patient Reminders which may include postcards, letters, telephone reminders email reminders
  To Business Associates who perform third party services such as billing.

To The U.S. Department of Health & Human Services (HHS)

We may disclose your information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death or Organ Donation

We may disclose your health information to a corner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs. If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use for marketing purposes (c) to sell your PHI; and (d) to disclose your PHI for any purpose not previously described in this notice

We also will obtain your authorization before using or disclosing your PHI when required to do so by (a)state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

Patient Rights

You have the following rights related to your health information:

Restrictions - You have the right to request restrictions on the use or disclosure of your health information for treatment, payment or healthcare operations in addition to the restrictions imposed by federal law.

Confidential Communications - You have the right to request that we communicate with you by alternative means or at an alternative location.

Inspect & Copy of Your Health Information - You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. Please let us know if you would like a copy of your records. There may be a fee to duplicate and assemble your copy; we will let you know if any fees are involved.

Amend Your Health Information - You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. Your request may be denied if the information record in question was not created by our office. Denial of your request will be accompanied by an explanation.

Accounting & Disclosures of Your Health Information - You have the right to ask us for a description of how and where your health information was disclosed. Please let us know in writing the time period for which you are interested, no more than six years at a time.

Request a Paper Copy of this Notice

Receive Notice of a Security Breach

Changes to the Notice

Complaints-You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting complaints to our privacy officer.

Rocket City Dental
112 Lily Flagg Rd. Suite B Huntsville, Al. 35802
Telephone: 256-881-3600
E-mail: rocketcitydentalhsv@gmail.com

Patient Acknowledgement

Patient Name:_____

Patient Signature:_____

Date:_____/_____/_____

Rocket City Dental

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.
By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Policy. The patient has the right to restrict the use of their information. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore payment in full is required at the time services are rendered.

Information SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
This HIPAA Consent/Sharing was signed by (Signature) (Today's date)

_____
Relationship to patient (if other than patient)