- Other Uses and Disclosures:

  We may use or disclose your PHI in the following situations without your authorization. These situations include: other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, correctional institutions, and workers compensation, where applicable.

- Other Permitted and Required Uses and Disclosures: Will be made only with your Consent, Authorization, or Opportunity to Object unless required by law.

- You may revoke this authorization, at any time, in writing, except to the extent that "the practice" has already taken action in reliance on your prior authorization.

Section C – Your Rights Concerning PHI

- You have the right to inspect and copy your PHI
- You have the right to request a restriction of your PHI
- You have the right to request to receive confidential communications from us by alternative means or at alternative locations. You have the right to obtain a paper copy of this notice from us, upon request.
- You may have the right to have your dental healthcare professional amend your PHI.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

"The practice" is required by law to abide by the terms of this *Notice of Privacy Practices*, and will allow you to review this prior to granting consent. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Section D – Complaints

If you believe your privacy rights have been violated, you may complain to us or to the Secretary of Health and Human Services. You will need to describe in detail the manner in which you feel your privacy rights have been violated. "The practice" will not retaliate against you in any way for filing a complaint with them, or with the Secretary.

Section E – Acknowledgment And Consent Of Disclosure

By signing this form you are consenting to our use and disclosure of your health information to carry out (only) treatment, payment activities, and healthcare operations. You have the right to revoke this consent at any time by giving us written notice of your revocation by Certified Mail.

_____ _____

Printed Name of Patient Signature of Patient or Responsible Party

_____ _____

Date Signed Witness

This notice was published and becomes effective on/or before April 14, 2003.

FRONT/BACK DOCUMENT