Notice of Privacy Practices

Office name: Address: Phone:

Website: Effective date of this notice:

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.

Our duties

We are required by law to maintain the privacy of your protected health information, to give you this notice of our legal duties and privacy practices, and to notify you if a breach of your unsecured protected health information occurs.

We must follow the terms of the notice currently in effect.

We will not use or share your information other than as described in this notice unless you tell us we can in writing.

How we use and share your information for treatment, payment and operations

Treatment. We use your health information to provide your dental care and share it with other professionals who treat you. Example: we send your x-rays and chart notes to an oral surgeon or orthodontist we refer you to.

Payment. We use and share your information to bill and get paid by dental or health plans or other payers. Example: we send your dental plan the treatment codes and dates of service so it will pay for your care.

Health care operations. We use and share your information to run our practice, improve your care and contact you when needed. Examples: we review records to check the quality of care, train our staff, and send appointment reminders.

When you can tell us your choices

You can tell us whether we may share information with family, close friends or others involved in your care or payment for your care, and whether we may share it for disaster relief. If you cannot tell us, for example if you are unconscious, we may share it if we believe it is in your best interest, and we may share it when needed to lessen a serious and imminent threat to health or safety.

Other ways we may use or share your information without your written authorization

The law allows or requires these uses and disclosures, each with conditions that must be met first:

- When a federal, state or local law requires it, including to the U.S. Department of Health and Human Services if it wants to see that we comply with federal privacy law.
- For public health activities, such as preventing or controlling disease, reporting adverse reactions to medications and helping with product recalls.
- To report suspected abuse, neglect or domestic violence to an agency authorized to receive the report.
- To health oversight agencies for activities authorized by law, such as audits, inspections and licensure.
- In response to a court or administrative order, or a subpoena or other lawful process.
- For law enforcement purposes or with a law enforcement official.
- To a coroner, medical examiner or funeral director.
- To organ, eye or tissue donation organizations.
- For research, when the law's conditions for research are met.
- To prevent or lessen a serious threat to anyone's health or safety.
- For special government functions, such as military, national security and presidential protective services.
- For workers' compensation or similar programs.

Substance use disorder records

If we receive substance use disorder treatment records subject to 42 CFR part 2, or testimony relaying the content of those records, we will not use or share them in civil, criminal, administrative or legislative investigations or proceedings against you unless you give written consent, or a court orders it after you or the holder of the record had notice and a chance to be heard. A court order must be accompanied by a subpoena or other legal requirement compelling disclosure.

State laws that give you more protection

Describe any state law or other law that limits these uses and disclosures more strictly (for example, rules for mental health, HIV or genetic information). If none apply, write "None."

Uses that need your written authorization

We will never use or share your information for these purposes unless you give us written permission: marketing, sale of your information, and most sharing of psychotherapy notes. Any other use or disclosure not described in this notice will be made only with your written authorization. You may revoke an authorization at any time by telling us in writing. Revoking it does not undo what we already did in reliance on it.

Your rights

To use any of these rights, contact the person named on the last page of this notice.

See and get a copy of your records. You can ask to see or get an electronic or paper copy of your dental record and other health information we have about you, including x-rays. We will act on your request no later than 30 days after we receive it. We may charge a reasonable, cost-based fee.

Ask us to correct your records. You can ask us to correct information you think is wrong or incomplete. We may say no, but we will tell you why in writing. We will act on your request no later than 60 days after we receive it.

Ask for confidential communications. You can ask us to contact you in a specific way (for example, a cell phone instead of home) or to send mail to a different address. We will say yes to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain information for treatment, payment or our operations. We are not required to agree. If you pay for a service or item out of pocket in full, you can ask us not to share information about it with your health plan for payment or our operations, and we will say yes unless a law requires us to share it.

Get a list of those we shared your information with. You can ask for a list (accounting) of the times we shared your information in the six years before your request, who we shared it with and why. It does not include disclosures for treatment, payment and operations, and certain others, such as ones you asked us to make. The first list in any 12 months is free; we may charge a reasonable, cost-based fee for another.

Get a paper copy of this notice at any time, even if you agreed to receive it electronically.

Choose someone to act for you. If someone is your legal guardian or has your medical power of attorney, that person can use your rights. We will check that the person has this authority before we act.

Complaints

If you believe your privacy rights have been violated, you can complain to us by contacting the person named on the last page. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint. We will not retaliate against you for filing a complaint.

Changes to this notice

We reserve the right to change the terms of this notice and to make the new terms apply to all health information we keep about you. If we change it, the new notice will be available on request, posted in our office and on our website, and copies will be at the front desk.

Choices this office makes (tick each that applies)

- ☐ We do not use your information for fundraising.
- ☐ We may contact you to raise funds for this office. You have the right to opt out of these communications, and we will tell you how each time.
- ☐ We never market or sell your personal information.
- ☐ You can see your records through our online patient portal at:
- ☐ We may give you this notice by email if you agree. If the email fails, we will give you a paper copy.

Who to contact

For more information, to use your rights, or to make a complaint, contact our privacy contact:

Name or title: _____ Phone: _____ Email: _____

Mailing address: _____

Effective date

This notice is effective on (not earlier than the date it is printed or published): _____

For the office: content required by 45 CFR 164.520(b)(1), wording based on the HHS model notice for health care providers (revised February 2026). Give the notice no later than the first service delivery, keep copies at the office for patients to take, post it in a clear and prominent location, and post it on your website (164.520(c)). Keep each version you issue, and signed acknowledgments or your notes of good faith efforts, for 6 years (164.520(e), 164.530(j)). This is a template, not legal advice: have it checked against your state's laws.

Acknowledgment of receipt of Notice of Privacy Practices

Office name: _____ Effective date of the notice given: _____

I received a copy of this office's Notice of Privacy Practices. It explains how the office may use and share my health information, my rights about that information, and how to contact the office or file a complaint.

- ☐ I received a paper copy
- ☐ I agreed to receive it by email, and I know I can ask for a paper copy at any time

_____ _____

Patient name (print) Date

_____ _____

Signature of patient or personal representative If signed by a personal representative: name and authority to act

For the office: if the acknowledgment was not signed

Required by 45 CFR 164.520(c)(2)(ii): document the good faith effort and the reason, except in an emergency treatment situation.

- ☐ The notice was given, but the patient declined to sign
- ☐ The patient could not sign. Reason:
- ☐ Emergency treatment. Notice to be given as soon as reasonably practicable afterward
- ☐ Other good faith effort and reason:

_____ _____

Staff name and signature Date

File this page in the patient's record and keep it for 6 years (45 CFR 164.530(j)). Do not copy patient information onto any other log or list.