DEARFIELD ORAL SURGERY
90 DEARFIELD DRIVE GREENWICH CT 06831

NOTICE OF PRIVACY PRACTICES AND TREATMENT CONSENT FORM

Patient Name: _____

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

PLEASE REVIEW CAREFULLY

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

- **TREATMENT**- means providing coordination or managing health care and related services by one or more health care providers. Examples of this would include teeth cleaning services, ordering a prescription from a pharmacy, a consultation or referred to a specialist.

- **PAYMENT**- means such activities as obtaining reimbursement for services, confirming coverage, billing and collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **HEALTH CARE OPERATIONS**- include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. Examples would be an internal quality assessment review and the use of a sign in sheet at the registration desk.

***We may also create and distribute de-identified health information by removing all references to individually identifiable information.**

***We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.**

***Any other uses and disclosures will be made only with your written authorization. You may resolve such authorization in writing and we are required to honor or abide by that written request except to the extent that we have already taken actions relying on your authorization.**

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include

- The right to request restrictions on the use and disclosure of your protected health information.

- The right to receive confidential communications concerning your health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.
  This notice is effective on or after April 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect**. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.** We will post and you may request a written copy of a Revised Notice of Privacy Practices from this office.

You have recourse if you fell that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice of the policies and procedures of our office.

By signing this document you acknowledge that you have read and understand these policies.

_____	_____	_____
Patient Signature	Relationship to Patient	Date