



NOTICE OF PRIVACY PRACTICES

To Our Patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the health insurance Portability and Accountability Act of 1996 (HIPAA)

Our Commitment To Your Privacy

- ☐ Our practice is dedicated to maintaining the privacy of your health information.
- ☐ We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information in Certain Special Circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement Official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Right Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home, rather than work. This may include contacting you by way of non-secured devices, such as answering machines, cellular phones, pagers, etc. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your information only to certain individuals in our care, such as family members and friends. If we do agree to your request, we are bound by agreement except when otherwise requested by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including therapy notes. You must submit your request in writing to Hammond & Proctor Dentistry Partnership. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Hammond & Proctor Dentistry Partnership.
6. Right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Hammond & Proctor Dentistry Partnership

**970 Camerado Drive Suite 100
Cameron Park, CA 95682
(530)677-0723 * FX (530)677-0366
www.hammondandproctordentistry.com**

**260 Palladio Parkway #1001
Folsom, CA 95630
(916)805-5077 * FX (916)293-8215**

I, _____ acknowledge I have received from Hammond & Proctor Dentistry a copy of the Dental Notice of Privacy Practices

I approve _____ as an individual who can view or discuss my dental records.

Signature: _____ Date: _____