**MONTANA DENTAL ARTS**
1920 S Russell St, Missoula, MT
59801, USA
**406-728-6068**

**Hipaa Informed Consent**

# Notice of Privacy Policy

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

## PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

The privacy practices described are currently in effect. We reserve the right to change our privacy practices, and the terms of this Notice at any time, provided such changes are permitted by law. If changes are made, a new Notice of Privacy policy will be displayed in our office and provided to patients. You may request a copy of our Notice at any time. Additional information may be obtained from the HIPAA Coordinator listed in our written HIPAA plan.

## USES AND DISCLOSURES OF HEALTH INFORMATION

The following describes how information about you may be used in this dental office:

Treatment Services: We may use or disclose your health information to all of our staff members, other dentists, your physicians, and/or other health care providers taking care of you.

Payment and Health Care Operations: We may use or disclose your health information to obtain payment for services we provide to you, to participate in quality assurance, disease management, training, licensing, and certification programs. Upon your written request, we will not disclose to your health insurer any services paid by you out of pocket.

Marketing/Fundraising: We will not use your health information for marketing or fundraising purposes without your written consent. You can opt out of receiving information about our marketing or fundraisers. We will not sell your health information without your explicit authorization.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail messages, text messages, emails, postcards, or letters.

Legal Requirements: We may use or disclose your health information when required to do so by law.

Abuse or Neglect: If abuse or neglect is reasonably suspected, we may use or disclose your health information to the appropriate governmental authorities.

National Security: When required, we may disclose military personnel health information to the Armed Forces. Information may be given to authorized federal offices when required for intelligence and national security activities. Health information for inmates in custody of law enforcement may be provided to correctional institutes.

Family Members, Friends, and Others Involved in Care: At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location, condition, or death.

Business Associates: Some services in our organization are provided through contacts with business associates. Examples include practice management software representatives, accountants, answering service personnel, etc. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. All of our business associates are required to safeguard your information and to follow HIPAA Privacy Rules.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Research: We may use or disclose medical information to researchers when an institution's review board or special privacy board has reviewed the proposed study and established protocols to ensure the privacy of the health information used in their research and determined that the researcher does not need to obtain your authorization prior to using your medical information for research purposes.

Public Health Activities: We may use or disclose your health information for public health activities, to include the following: to prevent or control disease, injury, or disability: to report reactions with medications or problems with products, to notify people of recalls of products they may be using to notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease of condition, to notify the proper government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (when required by law).

Other Authorizations: In addition to our use of your health information for treatment, payment, or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Breach Notification: We will notify you any time your PHI may have been compromised through unauthorized acquisition, use or disclosure.

Substance Use Disorder (SUD) Records: The confidentiality of substance use disorder patient records is protected by strict federal law and regulations (42 CFR Part 2). Generally, we may not disclose any information identifying a patient as having a substance use disorder unless:

- The patient consents in writing;
- The disclosure is allowed by a court order; or
- The disclosure is made to medical personnel in a medical emergency.

Information related to substance use disorder treatment cannot be used to criminally investigate or prosecute a patient.

Reproductive Health Care Privacy: We recognize that information regarding reproductive health care is highly sensitive. We will not use or disclose your protected health information to conduct a criminal, civil, or administrative investigation into, or impose liability for, the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.

Marketing and Fundraising: We will not use your health information for marketing or fundraising purposes without your written consent. You have the right to opt out of receiving fundraising communications from us. We will not sell your health information without your explicit authorization.

## PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information.

We will charge you a reasonable cost-based fee for expenses such as copies. If you request X-Rays, there will be a fee for any copies of films. You are not entitled to originals, only copies. Postage will be added if copies are to be mailed. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Details of all fees are available from the HIPAA Coordinator.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We will keep your information confidential from your health plans if you pay cash, at your request. In some instances, we may not be required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain the reason for the amendment) We may deny your request under certain circumstances.

## QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Policy or have questions or concerns, please contact us. If you have concerns relating to a perceived violation of your privacy rights, to access to your health information, to amending or restricting the use or disclosure of your health information, or to requesting alternative means of communication, you

may contact us using the contact information listed at the end of this Notice. You also may submit a written complaint to the Department of Health and Human Services (HHS). We will provide you with the HHS address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the HHS.

## PATIENT ACKNOWLEDGEMENT OF RECEIPT OF

## NOTICE OF PRIVACY PRACTICES

Patient First Name

Patient Last Name

Patient Birth Date

☐ I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to use and disclose health information about you for treatment, payment and health care operation purposes.

## HIPAA Release of Information Authorization

I give Dr. David Wilcox or an assigned representative of the practice, permission to discuss/disclose my health information (including information related to diagnosis, treatment, insurance status, account status, or pending appointments).

with the following exceptions:

List all authorized individuals

**Authorization Consent**

I understand that if a person contacts the office regarding my information and they are not on this list, there will be no information discussed with them. I understand that I can add/delete authorizations in writing, at any time. I understand that this authorization will be in effect until I revoke it in writing.

Legal representative's will be required to provide proof such as Power of Attorney, guardianship papers, court orders, photo ID, etc.

---

☐ I understand that this authorization is voluntary. My refusal to sign this authorization will not affect the treatment relationship I have with this practice. However, without your permission to speak to anyone, we will speak to no one.

## HIPAA Release of Information Communication Authorization

Please choose how we can contact you

☐ Text,

☐ Voicemail,

☐ Email,

☐ I give permission to send me information to the above communication channels. I understand that there could be financial, insurance or treatment information in the messages. I understand that by agreeing to email my PHI may be shared in an unencrypted format.

As part of our commitment to accurate and thorough patient care, our office may use audio recording during your visit. The sole purpose of this recording is to assist with clinical note-taking and documentation.

- **Use of Recordings**: Recordings will only be used by Montana Dental Arts staff for creating and maintaining your medical/dental record.
- **Confidentiality**: Recordings are treated as part of your protected health information (PHI) under HIPAA. They will be securely stored, accessed only by authorized staff, and not released without your written authorization unless required by law.
- **Voluntary Consent**: Your consent is voluntary. If you do not wish to be recorded, please let us know. Declining will not affect your ability to receive care in our office.
- **Retention**: Recordings will be securely deleted or destroyed once the related documentation is completed, unless otherwise required by law.

---

☐ By signing below, you acknowledge that you have been informed that recording may be used during your visit for the purpose of medical note-taking, and you consent to this practice.

## Signature

Signature By Patient

Date signed:

Patient's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature

Signature By Guardian

Name*

Relationship*

Date signed:

Legal Guardian's Signature

By drawing in the box above I understand and agree that this is a legal representation of my signature