



NOTICE OF PRIVACY PRACTICES

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

THESE ARE FEDERAL REGULATIONS. PLEASE REVIEW THEM CAREFULLY.

PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 01/01/2004, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. The new Notice will be effective for all health information that we maintain, including health information we create or receive after the effective date. You may request an updated copy of our Notice at anytime. For more information about our privacy practices, or for additional copies of the Notice, please contact us by using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist, physician, or other healthcare provider providing treatment for you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you. For example, we will send the necessary information to your health or dental insurance company to obtain payment for the treatment.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

We may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to begin your treatment. We may contact you by the following means of communication (1) mail, (2) telephone, (3) email, or (4) fax.

We will share your protected health information with business associates that perform specific functions for our practice such as billing. When a business arrangement of this type requires the use of your information, we will have a written contract with the third party to protect the privacy of your protected health information.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorizations to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. 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 the Notice or by law.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up fill prescriptions, medical supplies, x-rays, other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse of Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health or safety of others. Any disclosure will be made consistent with the requirements of applicable federal and state laws.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Inmates: We may use or disclose or disclose your health information if you are an inmate of a correctional facility and your facility created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of the Health and Human Services to investigate or determine our compliance.

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

PATIENT RIGHTS

Access: You have the right to look at or receive a copy of your health information, with limited exceptions. (You must make a request in writing to obtain access to your health information. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.00 for the most recent and pertinent radiographs or \$0.00 for a copy of the complete chart for staff time to locate and copy your health information, and postage if you want the copies mailed to you).

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. You must make this a restriction in writing and completely explain any and all restrictions you wish to be implemented to how we use your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (as required by law).

Disclosure Accounting: You have the right to receive a list of instances in which disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities but not before January 1, 2004 for up to the previous 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.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

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.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to the U.S. Department of Health and Human Services.

Privacy Officer: Beverly Copeland
Telephone: (919) 676-7846 Fax: (919) 676-6245
Address: 100 Sawmill Rd Ste 200
Raleigh NC 27615



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FEDERALLY MANDATED REGULATIONS REQUIRE THAT WE PROVIDE YOU WITH THIS INFORMATION. THANK YOU FOR ATTENTION AND COOPERATION IN THIS MATTER.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only (Do Not Fill Out This Section)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

Other (Please Specify)

I **do NOT** wish to be contacted by this office through the following means:

(List ALL that apply, i.e.: text, email, phone, mail, etc)



Authorization for Release of Information

NAME OF PATIENT _____ DATE OF BIRTH _____

Dr. Robert Kent and Associates is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

I hereby give permission for this Office to leave messages on the answering service/voicemail/text messaging/email

Cell phone _____ Email _____ Home _____ Office _____

I hereby give the following people permission to receive financial information from this Office on my behalf:

Name of Person Relationship to me (e.g., mother, friend)

Name of Person Relationship to me (e.g., mother, friend)

I hereby give the following people permission to receive dental records (treatment or appointment records) from this Office on my behalf:

Name of Person Relationship to me (e.g., mother, friend)

Name of Person Relationship to me (e.g., mother, friend)

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

*I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. **This authorization shall be in effect until revoked in writing by the patient.***

Please Print Name

Signature