NOTICE OF PRIVACY PRACTICES-HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHAT IS THE PROPOSE OF THIS NOTICE?

We respect the privacy of your health information and pledge to protect that information. This notice describes your rights and our duties on the subject of your health information. It defines how we may use and disclose your personal medical information. This notice applies to all information and records about your care that we have received or created.

OUR PROMISE TO YOU ABOUT OUR DUTIES AND RESPONSIBILITIES:

The law says we must protect the privacy of your information. The law requires that we need to give you this notice about what we do with the information we collect and maintain. We must follow the practices described in this notice. We will consider any reasonable privacy requests and agree to notify you if we are unable to meet those requests. We will not use or give out your information without your permission, except as described in this notice.

WHO WILL FOLLOW THIS NOTICE?

Our practice provides care to our patients together with staff, doctors and other health professionals. This notice will be followed by:

All employees, Doctors, and consultants of William H. Zovickian, DDS,
DBA Sharon Dental Associates

WHAT ARE YOU RIGHTS AS A PATIENT?

You have the following rights regarding your health information:

You have the right to ask us to limit how your personal medical information is used and given out for your care, for billing and for our business reasons. If you write to us and ask us to limit this information, we will consider your request. Please understand that under the law, we do not have to accept it. Your may also ask us to limit your medical information that we use and give out to a family member, friend or other person who is involved in your care or the payment for your care.

You have the right to see and get a copy of your billing records or other written information that we may use to make decisions about your care. In most cases, we may charge a reasonable fee for our costs in copying and mailing the information.

You have the right to request that we amend your health record if you believe that the information is wrong or if you believe that important information is missing. Your request must be made in writing and must list the reason for your request. You have the right to have a paper copy of this notice.

You have the right to ask that we communicate with you about your health matters in a different way or at a different place. For example, a specific phone number or mailing address. We will agree to reasonable requests.

WHO DO YOU CONTACT FOR MORE INFORMATION OR TO REPORT A PROBLEM?

If you believe that your privacy rights have been violated, you may file a complaint in writing with the practice by contacting the person listed below:

SHARON DENTAL ASSOCIATES
57 MAIN STREET
SHARON, CT 06069

You may also file a complaint with the Office of Civil Rights U.S. Dept of Health & Human Services

WHEN AND HOW WILL THE PRACTICE USE AND / OR GIVE OUT YOU PERSONAL MEDICAL INFORMATION?

We may use and disclose your health information for purposes of treatment, payment and health care operations (our business operations) without written permission. There are times when we must use your personal medical information. The practice MUST use and give out your personal medical information to provide information:

- To you or someone who has the legal right to act for you (your personal representative).
- To the Secretary of the Dept of Health and Human Services, if necessary, to make sure your privacy is protected.
- Where required by law, and in certain emergency circumstances.

SHARON DENTAL ASSOCIATES
57 Main Street
Sharon CT 06069
Tel: 860-364-0204

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient: ____

I hereby acknowledge that I received a copy of this medical practice's NOTICE OF PRIVACY and I may request a copy of any amended NOTICE OF PRIVACY.

Signed: _________________________________ Date: ________________

Print name: ____

If not signed by patient, please complete below.

Relationship to patient:

___parent ____legal guardian ____conservator ____patient's representative

For office use only:

____acknowledgment refused

Reason for refusal: ____

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