NOTICE OF PRIVACY PRACTICES

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

Permitted use and disclosure of your protected health information:

By signing this form, you authorize Meeker Endodontics to use or disclose your protected health and personal information for the following purposes:

Treatment. As required to evaluate your needs for treatment and follow-up care.

Payment. As required to obtain payment from insurance companies, or other financial institution relating to charges for your medical care.

Healthcare Operations. As required within our organization to evaluate treatment and business activities related to your treatment, specifically: Appointment reminders, Lab/X-ray results, Other health-care services that may be of interest to you.

We may also disclose your protected health information without further consent as follows:

Public Health Agencies. For purposes of reporting disease, vital statistics, or adverse effects from drugs, supplies or equipment.

Serious Threat to Health/Safety. For medical emergencies or in cases where imminent and serious health or safety issues exist.

Law Enforcement. To law and military officials for purposes of health delivery oversight, judicial or administrative proceedings, law enforcement and national security.

Required by Law. To State officials for management of financial audits, program monitoring and evaluation, licensure and certification.

Healthcare Oversight. To the Department of Health and Human Services for purposes of compliance investigations and reviews.

Research. To researchers when their research has been approved by an Institutional Review Board who reviews research proposals and established protocols to ensure the privacy of protected health information.

Worker's Compensation. To Employers as required by Texas Worker's Compensation Laws in case of a work related injury.

Victims of Abuse, Neglect or Domestic Violence. To appropriate enforcement agencies if there is evidence of abuse or neglect present in patient.

Note: Any other use or disclosure of your protected health information will only be made with your express written consent which you may revoke at any time in writing.

Your (Patient) Rights:

1. Request restrictions or limits on certain uses and disclosures of your protected health information. Although we may not agree to do so, you may request restriction in writing regarding certain information or to whom it is disclosed.

2. Request different ways for us to communicate with you regarding your protected health information.

3. Inspect and copy your protected health information. We will respond to your request within 30 days of receipt of written request. We may charge a reasonable fee for copying materials.

4. Request an amendment to your protected health information to correct or add information. We will comply within 60 days to any such written request and may deny your request if we determine that the information is incorrect.

5. You may object to disclosure of your protected health information to family members or public agencies. All objections must be in writing.

6. Receive a list of all disclosures made of your protected health information done for non-routine (treatment, payment, healthcare operations) purposes only. You may request disclosures that have occurred within the last six (6) years. Your first request in a 12 month period is free with additional request being charged a fee. We will comply to your request within 60 days of receipt of the written request.

7. Receive a paper copy of this notice upon request.

8. File a complaint if your believe that Meeker Endodontics has violated your privacy rights. You may file a written complaint with the HIPAA Compliance Officer at 335 E. Sonterra Blvd., Suite 100, San Antonio, TX 78258. You may also file directly with the Secretary of the Department of Health and Human Services, Officer of Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202, phone (214)767-4056, fax (214)767-0432, TDD (214)767-8940.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION.

____ ________________

Printed Patient's Name Date

I, ____ have received a
(Signature of Patient of Parent/Legal Guardian)

copy of the offices NOTICE OF PRIVACY PRACTICES as required by law.

I, ____ consent to the use
(Signature of Patient of Parent/Legal Guardian)

and disclosure of my personal health information by your office during Treatment, Billing/Payment, and Healthcare Operations as described in the Notice of Privacy Practices.