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 IT CAREFULLY!

I. Our Legal Responsibilities

This Privacy Notice is being provided to you as a requirement of a federal law known as the **Health Insurance Portability and Accountability Act ("HIPAA").** The Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information in some cases. Your **"protected health information"** means any written and oral health information about you, including demographic data that can be used to identify you.

We are required to follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on **April 14, 2003** and will remain in effect until we replace it.

As permitted by law, we reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you at your next visit to our Practice. You may request a copy of our Notice at any time.

II. Examples of Uses and Disclosures of Protected Health Information

Our Practice may use your protected health information for purposes of providing treatment, obtaining payment for treatment and conducting health care operations.

A. **Treatment:** We may use or disclose your health information to a physician or other health care practitioner providing treatment for you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. We also may disclose medical information about you to people who may be involved in your medical care, which may include your family member, or other personal representatives.

B. **Payment:** We may use and disclose your health information to obtain payment for services we provide to you. For example, we may need to give your health care information, regarding the treatment you received from us, to obtain payment or reimbursement for the care.

C. **Health Care Operations:** We may use and disclose your health information in connection with health care operations. Health care operations include such activities as: quality assessment and improvement activities, training programs, medical reviews, and employee review activities, licensing and credentialing programs.

D. **Uses of Information:** We may use a sign-in sheet or electronic sign in at the registration desk where you will be asked to sign in to the Practice. We may also call you by name in the waiting area when your physician is ready to see you, to contact you for your appointment.

E. **Your Authorization:** In addition to our use of your health information for our 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 an authorization, you may revoke it in writing 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.

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

G. **Persons Involved in Care:** unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. 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 health care. 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 filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

H. **Marketing Health Related Services:** We will not use your health information for marketing communications without your written authorization.

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

J. **Abuse and Neglect:** We may disclose your health information to public authorities as allowed by law to report abuse or neglect. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

K. **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

L. **Business Associates for Treatment, Payment and Health Care Operations:** We are permitted to disclose your health information to our business associates in order to carry out treatment, payment or health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the health care services we provide.

III. Your Health Information Rights:

You have the following rights regarding medical information we maintain about you.

A. **Right to Inspect and Copy:** You have the right to inspect and copy your protected health information, with limited exceptions. (The request to review your records must be made in writing to the Privacy Officer. You may obtain a form to request access by using the contact information at the bottom of this Notice). We may deny your request under certain circumstances. If you request a copy of your information, we may charge you a fee for the costs incurred by us in complying with your request. If you prefer, we may prepare a summary or an explanation of your health information for a fee.

B. **Right to an Accounting Disclosure:** 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, health care operations and certain other activities, for the last 6 years but **not before April 14, 2003**. 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.

C. **Right to Request Restrictions:** You have the right to request that we place additional restrictions on our use and disclosures of your protected health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

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

E. **Right to Request an 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. If we deny your request for amendment, you have the right to file a statement of disagreement and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

F. **Right to a Paper Copy of this Notice:** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

IV. Questions and Complaints

If you have any questions, would like additional information or want to report a problem regarding the handling of your information, please contact us.

If you are concerned that we may have violated your privacy 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 or disclosure of your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us by addressing a written complaint to the **Privacy Officer at Hulme Orthodontics, 15303 Huebner Road, Building 16, San Antonio, TX 78248**. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with the address to file your complaint with the United States Department of Health and Human Services upon request.

We support the right to the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Relationship to Patient