RIGALI ORTHODONTIX

CHANGING LIVES ONE SMILE AT A TIME

PRIVACY NOTICE

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.

We use and disclose health information about you for treatment, payment and healthcare operations. The following are some examples of how your health information may be used or disclosed:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, State dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders (such as postcards, letters or voicemail messages) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- The initials of your name only, medical/dental histories, photographs, x-rays and models may be used for educational purposes in professional lectures/presentations, publications, and/or research.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contract Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

Paul H. Rigali, D.D.S., P.C. *Diplomate of the American Board of Orthodontics*

217 103D Maxham Meadow Way • Suite 3D, Sunset Farm • Woodstock • Vermont •05091

Phone: 802-432-1087 • **Fax**: 802-432-1088

Email: orthodontix@rigaliorthodontix.com • **Website**: rigaliorthodontix.com

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THIS Privacy Notice.
(You may refuse to sign this acknowledgement)

_____
Patient's Name

_____ _____ _____
Please Print Your Name | Signature of Patient / Guardian | Date

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For Office Use Only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

Other- _____

_____ _____
Staff Person's Signature | **Date**

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HIPAA Privacy Authorization Form

****Authorization for Use or Disclosure of Protected Health Information**

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

****1. Authorization****

I authorize Rigali Orthodontix to use and disclose the protected health information described below to _____ (individual seeking the information).

****2. Effective Period** This authorization for release of information covers the period of healthcare from:**

a. □ _____ to _____. **OR b. □ all past, present, and future periods.**

****3. Extent of Authorization****

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR** b. □ I authorize the release of my complete health record with the exception of the following information: □ Mental health records**

□ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____ _____

Printed name of patient or personal representative and his or her relationship to patient **Date**

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