Notice to Patients of Privacy Practices

This notice describes how medical information about your child may be used and disclosed. We are required by law to protect the privacy of your and your child's protected health information. This document also explains how you can gain access to your child's medical information and who to contact should you have any complaint. Please read this document carefully and sign the form to acknowledge you have received this notice.

A. The general consent for release of medical records you sign authorizes All-Star Smiles 4 Kids to disclose the information in your child's medical records for treatment, payment, and health care operations:
   1) For the purpose of providing, coordinating, or managing your child's treatment and related services. Your and your child's information may be shared with employees and contractors of the provider, or with other health care providers who are treating your child or consulting in your child care.
   2) For the purpose of arranging payment for your child's care. Your information may be shared with your insurer or other third party payor who is responsible for paying all or part of the cost for your child's care. This may include certain activities your health insurance plan or workers compensation insurer requires before it approves or pays for health care services we recommend.
   3) For the purpose of health care operations. We may use and disclose information that is necessary for our business operations, e.g., internal quality assessments, contacting other health care providers about treatment alternatives. We may use information about your child to remind you by telephone, letter, or postcard of an appointment for treatment of medical care or to notify you of a diagnostic test result.

B. You may be asked to sign a specific authorization for release of medical records, which will authorize us to make a specific disclosure that is not covered under Section A above. The specific information, the entity to whom it will be disclosed, and the purpose for which it will be used will be documented for your review before signing.

C. You may revoke any consent or authorization provided to us by giving a written notice of revocation.

D. We may be required by law to disclose your records that you have not authorized. Examples of these situations include but are not limited to, complying with workers compensation laws, receiving a subpoena for the records, or if public responsibility requires disclosure, e.g., to protect public health. We will keep all disclosures of your child's medical records to the minimum necessary.

E. Your rights regarding health information about you:
   1) You have the right to inspect a copy your child's health information.
   2) If you feel that the health information we have about your child is incomplete or inaccurate, you have the right to request an amendment to your child's medical records. The request must be made in writing with the reason that supports your request. If we do not agree with your request, you have the right to ask that your statement be placed in the medical record.
   3) You have the right to find out how your child's health information is used and to whom it is disclosed. You may request an accounting of your child's medical record disclosures made by us except for disclosures made for treatment, payment, and health care operations covered in Section A.

F. We are required by law to maintain the privacy of your and your child's protected health information and if you believe that your or your child's rights have been violated, you may complain to the Secretary of the U.S. Department of Health and Human Services or complain to us by talking to us, calling us, or writing to us with details. We will not retaliate in any way against a patient, parent or guardian for making a complaint.

G. We reserve the right to change our privacy practices and to make new policies effective for all protected health information that we maintain. If we should do so, we will issue an updated "notice to patients" to all of our patients' parents and/or guardians.

ACKNOWLEDGEMENT AND ACCEPTANCE OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement

I ____________________________ have been offered a copy of this office's Notice of Privacy Practices and agree with its provisions.

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Relationship to Patient

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Signature

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Date

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

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