

## **Westport Pediatric Dentistry Notice of Privacy Practices**

**This notice describes how your child's information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your child's information is important to us. Note: We will not disclose any of your child's health information without your consent.**

### **OUR LEGAL DUTY**

Federal and state laws require us to maintain the privacy of your child's health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your child's health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect on October 1, 2012 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make 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 upon request. For more information about our privacy practices or additional copies of this Notice, please inquire.

**Treatment:** We disclose medical information to our employees and others who are involved in providing the care your child needs. We may use or disclose your child's health information to another dentist or other healthcare providers providing treatment which we do not provide. We may also share your child's health information with a pharmacist in order to provide your child with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

**Payment:** We may use and disclose your child's health information to obtain payment for services we provide; unless you request that we restrict such disclosure to your child's insurance plan when you have paid out-of-pocket and in full for services rendered.

**Your Authorization:** In addition to our use of your child's health information for treatment or payment; you may give us written authorization to use your child's health information or to disclose it to anyone for any purpose. If you give us a written 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 is 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.

**Unsecured Email:** We will not send you unsecured emails pertaining to your child's health information without your prior authorization via e-mail or verbally. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

**Persons Involved in Care:** 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 child's healthcare. We may also contact the Emergency Contact you've listed in the event of an emergency. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your child's best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

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

**Abuse or Neglect:** We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety or the health or safety of others.

## **ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Westport Pediatric Dentistry's HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Relationship to Patient (Check One):

Parent     Guardian     Other: \_\_\_\_\_