PARK DENTAL GROUP PC
480 PARK STREET, STOUGHTON, MA 02072
781-344-5211

Medical Information Release Form
(HIPAA Release Form)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

****You May Refuse To Sign This Acknowledgment****

I have received and reviewed a copy of the notice of privacy practices for Park Dental Group, PC.

Patient's Name: _____

Signature: _____
Parent or guardian if under 18-years of age

Date: _____

Optional Consent Requested

I authorize the use of my home phone, cell phone and email address for use in communication regarding scheduling and confirmation of appointments, as well as communication regarding treatment that is planned or has already been rendered and statements of account.

Initials: ☐

Cell Phone: _____

Email Address: _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our notice of privacy, but acknowledgment could be obtained because:

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

Staff Member:

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NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully

The privacy of your health information is important to us

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the notice about our privacy practices, our legal duties, and your rights concerning your help information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, 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 the changes to our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created o:· 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.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice please contact us using the information listed at the end of this notice.

USES AND DISCLOSURESOF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

TREATMENT: we may use or disclose your health information to a physician or other health-care provider providing treatment to you. We may review your treatment, treatment objectives, or treatment options with other dentists in order to provide the best quality of care.

PAYMENT: we may use and disclosure health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: we may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: in addition to our use of your health information for 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 disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclosure health information for any reason except those described in this notice.

TO YOUR FAMILY and FRIENDS: we must disclose your health information to you as described in the patient right 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.

PERSONS INVOLVED IN CARE: we may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such use or disclosures. 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 persons involvement in your healthcare. 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.

MARKETING HEALTH-RELATED SERVICES: we will not use your health information for marketing communications without your written consent.

REQUIRED BY LAW: we may use or disclosure health information when we are required to do so by law.

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ABUSE OR NEGLECT: we may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. 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.

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 institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

APPOINTMENT REMINDERS: we may use or disclosure health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT'S RIGHTS

ACCESS: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We may charge you a reasonable cost base fee for expenses such as copies and staff time. This fee is $30.

DISCLOSURE ACCOUNTING: 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, healthcare operations and certain other activities, for the last six years, but not for April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, costs based fee for responding to these additional request.

RESTRICTIONS: you have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by her agreement (except in the case of emergency).

ALTERNATE COMMUNICATIONS: you have the right to request that we communicate with you about your health information by alternate means or to alternate locations. You must make your request in writing. Your request must specify the alternate means or location, and provide satisfactory explanation of how payments will be handled under the alternate means or location you request.

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.

QUESTIONS AND COMPIAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at regular business hours.

If you are concerned that we may have violated your privacy rights or disagree with a decision we made about access to your health information or response to request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternate means or at an alternate location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with an address to file your complaint with the US Department of Health and Human Services upon request.

We support your right to the privacy to help information. We do not retaliate in any way if you choose to file complaint with us or with the US Department of Health and Human Services.

CONTACT OFFICER:

Dr. Theresa Bain Recupero
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Stoughton, MA 02072
781-344-5211
pkden3@comcast.net