

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“**HIPAA**”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally be kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information.

As required by “HIPAA” we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may also contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the **Privacy Officer** - Nkemakonam Egolum, DDS, Tel: 301-383-9883, Email: info@bowieoralsurgery.com, Fax: 301-349-1447:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not, however, required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.



4175 N Hanson Court, Suite 200
Bowie MD, 20716
Tel: 301-383-9883 Fax: 301-349-1447
www.BowieOralSurgery.com

We are required by law to maintain the privacy of your protected health information and to provide you with the notice of our legal duties and privacy practices with respect to protecting your health information.

This notice is effective as of September 8th, 2018, and we are required to abide by the terms of the Notice of Privacy Acts currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of any revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office and with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services, Office of Civil Rights

200 Independence Avenue, S. W. Washington, D.C. 20201 (202) 619-0257

Toll Free: 1-800-696-6775

Patient (Guardian) Signature: _____

Date: _____



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Consent for Disclosure of Information

I have reviewed the “Notice of Privacy Practices” of Bowie Oral Surgery and have had all questions answered by this office.

I also consent to the use or disclosure of my protected health information for the following purposes:

Treatment

It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

Payment

Necessary information will be shared with the appropriate payer sources and their representatives for payment including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel including but not limited to employees, case managers, claims representatives, third party billing services or clearing houses to have access to protected health information to carry out their job functions.

Healthcare Operations

Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

Patient Name (Printed): _____ Date: _____

Patient Signature (or parent/ legal guardian): _____