NOTICE OF PRIVACY PRACTICES POLICY

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.

Understanding Your Medical Record/Health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examinations and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the Practice of your requests for any of these actions:

1. Request Restrictions: You have a right to request restrictions on the use of your information.
2. Obtain a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice.
3. Inspect and Copy: You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
4. Amend: You have the right to request that we amend your health information.
5. Obtain an Accounting of Disclosures: You have the right to request an accounting of certain disclosures of information that have been made about you. This listing includes those disclosures of your information other than treatment, payment or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
6. Request Communications of your Health Information: You have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
7. Revoke Your Authorization for Disclosure: You have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

1. Confidentiality: Maintain the privacy of your health information.
2. Provide a copy of this notice: We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
3. Abide by the terms of this notice.
4. Unable to restrict: We will notify you if we are unable to agree to a requested restriction of your information.
5. Provide alternative means or alternative locations: We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
6. We reserve the right to charge our privacy practices and to make new provisions effective for all protected health information we keep. Should our information practices change, we will notify you of these changes when you return to our office.
7. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information

1. If you have a question or would like additional information, you may contact our privacy officer.
2. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of Health and Human Services in the U.S. Office of Civil Rights. The privacy officer will supply information about this procedure.

Examples of Disclosures of Information

1. Treatment:
    a. We will use your health information for treatment purposes. As an example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare team will document your treatment goals, actions taken and clinical observations.
    b. We will provide your other healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.
2. Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments and supplies used.
3. Healthcare Operations: The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.
4. Business Associates: There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.
5. Notification: We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.
6. Communication with family: We will use good judgment in disclosing to a family member or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.
7. Funeral Directors: We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
8. Organ Donation: If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation purposes.
9. Marketing: We may 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.
10. Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.
11. Workers Compensation: In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.
12. Public Health: Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury or disability.
13. Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
14. Health investigation: Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.
15. Other disclosures: All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Acknowledgement of Receipt of Privacy Practices

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

_____ _____

Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative

Acknowledgement of Receipt of Privacy Practices and Designation of Care Providers

I hereby acknowledge that I have been given an opportunity to review the privacy practices at Ai Family Dental. I understand that I may obtain a copy of the Notice of Privacy Practices.

This notice has been issued and considered effective on the date signed. We will keep this signed form on file for a minimum of six (6) years.

I hereby request that my protected health information be communicated with others directly involved in my care. This designation of care providers will be kept as a permanent part of my medical record and will be copied as required in order to allow communication of my protected health information. I understand that my health care providers will use judgment in determining the minimum amount of information that must be shared in order to care for me.

DESIGNATION OF CARE PROVIDERS: (Specify name, relationship, agency, healthcare provider, etc. that will be allowed information as needed for your treatment)

_____
_____
_____
_____

_____ _____
Signature of Patient/Representative and Relationship to Patient Date

_____ _____
Signature of Practice Representative Date

Consent for Disclosure of Protected Health Information for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Dr. Yen-yo Liao for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Ai Family Dental. I understand that diagnosis or treatment of me by **Dr. Yen-yo Liao** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Ai Family Dental is not required to agree to the restrictions that I may request. However, if Ai Family Dental agrees to a restriction that I request, the restriction is binding on Ai Family Dental and **Dr. Yen-yo Liao**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Dr. Yen-yo Liao** or Ai Family Dental has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Ai Family Dental's Notice of Privacy Practices prior to signing this document. The Ai Family Dental's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Ai Family Dental. The Notice of Privacy Practices for Ai Family Dental is posted in the reception area of the office. This Notice of Privacy Practices also describes my rights and the Ai Family Dental’s duties with respect to my protected health information.

Ai Family Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Initial here if Notice of Privacy Practices Brochure was given. _____

_____ _____

Signature of Patient or Personal Representative Date

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Name of Patient or Personal Representative