TO OUR PATIENTS

This notice describes how health information about you (as a patient at Keystone Dental Care, Inc.) may be used and disclosed, and how you can get access to your health information.

This is required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

This notice takes effect April 14, 2003 and will remain in effect until it is replaced

Keystone Dental Care, Inc.
603 Bert Street Box 12
Suite 206
Johnson City, Tennessee 37601
(423) 232-7919

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State of Tennessee ARC
City of Johnson City
Mountain States Health Alliance
Iris Glen
Noon Rotary of Johnson City
Keystone Dental Care, Inc is a United Way Agency
**OUR COMMITMENT TO YOUR PRIVACY**

Keystone Dental Care, Inc., its staff and volunteers are dedicated to maintaining the confidentiality of your health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. New Privacy Practices will be posted and made available upon request.

We realize that these laws are complicated, but we must provide you with the following information:

### USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN SPECIAL CIRCUMSTANCES

The following circumstances may require us to use or disclose your health information.

1. To public health authorities and health over-site agencies that are authorized by law to collect information.

2. To volunteer dental care providers in order to prevent a threat to your health in the administration of medications and treatment.

3. In connection with our health care operations, including training programs, case studies, certification, licensing and credentialing activities.

4. If required to do so by a law enforcement official.

5. When it is necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We will only make information available to persons or organizations able to help prevent the threat.

6. You may give us written permission to disclose your health information to a family member, friend or other person, when it is necessary to help with your healthcare.

7. Our clinic will not use your information for case studies or marketing communications without your written consent.

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

9. To proper authorities in situations of national security.

10. To provide appointment reminders.

### YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You have the right to ask that our clinic communicate with you about your health and related issues in a particular manner or a certain location. You must submit these requests in writing.

2. You can request a restriction in our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we are bound by these restrictions, EXCEPT IN THE CASE OF EMERGENCY.

3. You have the right to obtain a copy of, or look at your health information, with the exception of clinic notations, which will be provided only to another health care provider. You must provide a written request for treatment notes to be transferred to another health care provider.

4. You may request to change your health information if you believe that it is incorrect or incomplete.

5. You have the right to request a copy of this notice at any time.

6. You have the right to request a list of instances in which your health information has been disclosed.

7. You have the right to file a complaint. If you believe that your privacy rights have been violated. You may file a complaint with this clinic or U. S. Department of Health and Human Services. This complaint must be submitted in writing.
I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices

Patient Name: ____________________________________________________
(Please Print Name)

Signature: _____________________________ Date: ___________

I give my consent for the following people to receive my personal health information.

1. __________________________________________________
2. __________________________________________________
3. __________________________________________________

Signature: _____________________________ Date: ___________