

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.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnose medical conditions, and providing treatment. When we provide treatment we may request that your primary care physician or other specialists share your medical conditions, if any. In addition, results of laboratory tests and procedures will be available in your dental record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your dental plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care options: Your health/dental information may be used as necessary to support the day-to-day activities and management of our practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspection to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health/dental information or its uses for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information:

Appointment Reminders: Your health/dental information will be used by our staff to send you appointment reminders via the telephone and/or electronic mail.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Practice Duties:

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices:

As permitted by law we reserve the right to amend or modify our policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information:

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations we require that requests to inspect or copy protected health information be submitted in writing.

Complaints:

If you would like to submit a comment or complaint about our privacy practices you can contact the Privacy Officer at the address shown below. If you believe that your primary rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the address below. You will not be penalized or otherwise retaliated against for filing a complaint.

You may also send a letter outlining your concerns to the U.S. Department of Health and Human Services.

Contact Person:

The name and address of the person you can contact for further information concerning our privacy practices is:

Annie Sterling – Privacy Officer
6020 Sherry Lane
Dallas, Texas 75225
214.369.3206

Effective Date:

This notice is effective on or after April 14, 2003

J. Michael Kidwell, D.D.S., P.A.

PF-2000 Acknowledgment of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

Relationship of Patient Representative to Patient