

Dental Care of Mclean
6711 Whittier Avenue, Suite 201
Mclean, VA 22101
(703)356-2020



Dental Care of Alexandria
1451 Belle Haven Road, Suite 430
Alexandria, VA 22307
(703)765-6400

Federal Law Mandates that you be informed of our practice policy regarding your protected health information

Notice of Privacy Practices for protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

With your consent the practice is permitted by federal privacy laws to make uses and discloses of your health information for purposes of treatment payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations and test results, diagnoses, treatment, and apply for future care or treatment. It also includes billing documents for these services.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the areas. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding treatment given. We will provide information to them about you and the care given.

Example of use of your Health Care Operations:

We obtain services from our insurers or other business associates as a quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

-The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosers of your health information by delivering the request in writing to our office. We are not required to grant the request but will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record-you may exercise the right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office.
- File a statement of disagreement if your amendment is denied, and require that the request for an amendment and any denial be attached in all future disclosers of your protected health information.
- Obtain an accounting of disclosers of your health information as required to be maintained by law by delivering a written request to our office. Disclosers made to family members or friends in the course of providing care;
- Request that communication of your health information be made by an alternative means or at an alternative location by delivering the request in writing to our office and;
- Revoke authorizations that you made previously to use or disclose information except to the extend information or action already been taken by delivering a written revocation to our office.

Our Responsibilities:

- The practice is required to:
- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information to you.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint to:

**Secretary of Health and Human Services
The Public Ledger Bldg, 150S
Independence Mall West, Suite 372
Philadelphia, PA 19106-3499**

I, _____ hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask questions I may have regarding this notice.

Patient or Parent/Guardian Signature: _____ Date: _____