



**Acknowledgement of Receipt of  
Notice of Privacy Practices**

*\*\*You May Refuse to Sign This Acknowledgment\*\**

I have received a copy of this office's **Notice of Privacy Practices**.

---

{Please Print Name}

---

{Signature}

---

{Date}

---

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because:

- Individual refused to sign this notice.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other: (Please Specify) \_\_\_\_\_

---

Staff Signature & Date



## Notice of Privacy Practices

Dentists, like all healthcare providers, are required by law after April 14, 2003 to inform their patients of their privacy rights and rights of access to their health information. We support such legislation. You will find we have always gone beyond the minimal standards established by law to ensure the confidentiality of your health information. We reserve the right to change our practices as laws evolve and will make our new Notice available upon request. We encourage your questions, thoughts, or concerns about our policies.

---

## Use and Disclosure of Health Information

We use and disclose health care information about you for treatment, payment, and healthcare operations.

- We may disclose or discuss your health information to aid a physician or healthcare professional providing treatment for you.
- We may use and disclose your health information to obtain payment for services we provide you.
- We may use and disclose your health information in connection with our healthcare operations. Healthcare operations can include quality assessment, accreditation, certification, licensing or credentialing activities.

Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice

**Your Authorization:** You may also give us permission to use your health information or to disclose it to anyone for any purpose that you choose. An example would be to give us permission to discuss your dental needs with a spouse. You may revoke, in writing, any additional authorizations at anytime.

**To Your Family and Friends:** With limited exceptions, we may disclose health information of minors to their parent or legal guardian. We cannot, by law, disclose any information about an adult to other family members or friends without your permission. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or for payment of your health care, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of a family member or representative in the event of an emergency where we feel, in our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment with common practices to make reasonable inferences of your best interest in allowing a person to pick up written prescriptions, radiographs, or other similar forms of health information.

**Marketing Health Related Services:** We will not provide your health information to anyone for marketing purposes.

**Required by Law:** We may use or disclose your health information when required to do so by law. We may disclose information if we believe you are a possible victim of abuse or domestic violence or avert a serious threat to your health or safety or the health or safety of others. We may disclose health information in instances of National Security.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) unless you asks us not to.

## Patient Rights and Access to Their Health Information

**Access:** You have the right to review your dental record or obtain copies, with limited exceptions. You may request that we provide copies in a format other than photocopies and we will use the format you request unless we cannot practically do so. All requests for access to your dental records must be made in writing and sent to the address at the bottom of this Notice. You may also obtain a form to request access by using the contact information at the end of this notice.

- We will (continue to) transfer current radiographs and information we deem as pertinent directly to any health care provider that requests them at no charge.
- We will charge you a reasonable cost-based fee for expenses associated with the duplication of pages of your dental record, radiographs, mailing, and office staff time for duplication services for any other purpose. If you prefer, we will prepare a summary or an explanation of your health information for a cost-based fee. We will provide you with a current fee schedule for these services at anytime upon your request.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. Except in an emergency or dictated by law, we will abide by your requests provided we agree to them.

**Disclosure Accounting:** You have the right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, or healthcare operations after April 14, 2003. (We have never disclosed such information since our practice inception on June 26, 1989 to April 14, 2003. After April 14, 2003 we are required to obtain written permission from you prior to any disclosures.)

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

---

## Questions and Complaints

Maintaining the privacy of your health care information and your access to such information is important to us. If you want more information or have questions or concerns, please contact us.

If you feel we have violated any of your rights, please contact us immediately as it is important to us that we resolve any discrepancies you feel we committed. You may also submit a written complaint to the U.S. Department of Health and Human Services and we can provide you with the appropriate address upon request. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.

**Contact Officer:**

**Paul W. Callahan, D.D.S.**

**14 Pidgeon Hill Drive, Ste. 200, Sterling, VA 20165**

**703.444.4104 | FAX 703.444.9344 | CallahanDental@aol.com**

American Dental Association Privacy Practices Form modified and used with permission