Geshay Pediatric Dentistry, P.C.
Notice of Privacy Practices

At our practice, we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose this information. It also describes your rights as they relate to your protected health information. This Notice applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR HEALTH RECORD

Each time you visit our practice, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- Tools in educating health professionals
- Source of data for medical research
- Source of information for public health officials charged to improve the health of the state and nation
- Source of data for our planning and marketing
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may assess your health information, and make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of our practice, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request
- Inspect and copy your health record as provide by 45 CFR 164.524
- Amend your health record as provided by 45 CFR 164.526
- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164.528
- Request confidential communications of your health information as provided by 45 CFR 164.522
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522 (our practice, however, is not required by law to agree to a requested restriction)

OUR RESPONSIBILITIES

Our practice is required to:

- Maintain the privacy of your health information. Due to physical constraints, we will attempt to be discreet as possible
- Provided you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate your health information

We reserve the right the change our practices and to make the new provisions effective for all protected health information we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top right-hand corner. In addition, each time you visit our facility for treatment, you may obtain a copy of the current notice in effect upon request.

We will not use or disclose your health information in a manner other than allowed by law without your written consent.

If you have any questions or would like additional information, you may contact our practice's Privacy Officer at (724) 439-1576.

If you believe your privacy rights have been violated, you can either file a complaint with our Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, pament activities and healthcare operations.

Signature : _____ Date : _____