Dumont Family Dental
Dr. Christopher J. Restieri 110 West Shore Ave . Dumont NJ . 07628 201.384.9519

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment of healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Processed health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physical practice, and other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your protected healthcare information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization, these situations include as required by law, public health issues as required by law, communicable diseases, health oversight abuse or neglect. Food and drug administration requirements; legal proceedings; law enforcement; coworkers; funeral directions and organ donation; research criminal activity; military activity, and national security; workers compensation; inmates; required uses under the law; we must make disco less to you and when required by the secretary of the department of health and human services to investigate or determine our compliance with the requirements of section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW

YOU MAY REVOKE THIS AUTHORIZATION, anytime in writing, except to the extent that your physician's practices has taken an action in reliance on the use or disclosure indicated in the authorization.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION: Under federal law you may not inspect or copy the following records; information complied in reasonable anticipation of, or use in, a civil, or criminal action.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request us not to disclose your information to family members or friends who may be involved in your care.

YOU HAE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE. We will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: you may complain to us if you believe your privacy rights have been violated.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES

Patient Signature: _____ Date:____/____/_____