Lee N. Sheldon, DMD, PA

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 07/01/2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

Person Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Lee N. Sheldon, DMD • Dental Implants / Periodontics
Matthew E. Sheldon, DMD • Restorative and Cosmetic Dentistry
Michel Furtado, BDS, MSc, MDS • Periodontist (board certified)

Health Information Release Form

In order to assist you in receiving your health information from our office, please complete this form.
I, authorize the persons listed below to have access to any and all of my health information. This office is permitted to share any information with them that is disclosed during office visits.

Persons authorized to receive my information (full name, relationship and phone number):

Name	Relationship	Phone Number

__ You may notify me or the parties listed above with any information regarding my treatment including appointment reminders, treatment information or prescriptions as follows:

Please mark below which you authorize

__ Message on home answering machine

__ Message work voicemail

__ Message on cell phone

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____	_____
Print Name	**Patient Signature**
_____	_____
Patient Date of Birth	**Today's Date**

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YOUR SIGNATURE IS NECESSARY FOR US TO:

1. ***Process all insurance claims,***
2. ***To ensure payment for services rendered,***
3. ***To release medical information to insurance companies, AND***
4. ***To release and/or obtain information to/from other medical/dental providers, when necessary, for your treatment.***

I, authorize the release of all medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care

Patient Signature: _____ **Date:** _____

Responsible Party: _____

(Parent, if Minor ONLY)

Office Use Only:

Witness: _____

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