JEREMY ARCHIBALD DDS

FAMILY & COSMETIC DENTISTRY

STATEMENT OF PRIVACY PRACTICES

We, at Dr. Archibald's office are dedicated to protecting the rights of our patients, and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We reserve the right to amend our privacy policies and practices, but we will inform you of any changes that might affect your rights.

Protecting Your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Oregon. This includes issues relating to your treatment, payment, and our dental care operations. However, your personal protected health information will never be disclosed to anyone-even family members- without your written consent. You, of course, may give written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.
Our systems are secure from unauthorized access, and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and protocols apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include you name, address, telephone number(s), Social Security number, employment data, medical history, health history, health records, etc. While most of the information will be collected from you, we may also obtain information from third parties (i.e. medical doctor) if it is deemed necessary for your care. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, emails and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S Department of Human Services.

Acknowledgement of Receipt of Privacy Practices

I, acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Dr. Archibald. The notice of Privacy Practices describes the types of uses and disclosures of my protected healthcare. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility. Dr. Archibald reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected healthcare information to the persons indicated below. Please check below:

ANY MEMBER OF MY IMMEDIATE FAMILY	O YES O NO
SPOUSE	O YES O NO
OTHER (PLEASE SPECIFY): _____	O YES O NO

_____ _____

Name of Patient/Guardian (Please Print) Signature of Patient/Guardian

_____ _____

Date Description of Personal Representative's Authority