



# NOTICE OF PRIVACY PRACTICES

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This notice describes how health 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.

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## OUR LEGAL DUTY

Restore Complete Dental is required by applicable federal and state law to maintain the privacy of your health information. (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164). 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 1/1/2013, 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.

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## USES AND DISCLOSURES OF HEALTH INFORMATION

Restore Complete Dental primarily maintains your health information in a secure electronic format and will, at certain locations, also maintain your information in a paper format. Your information will most often be used, shared, or disclosed electronically for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a dentist, 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. Restore Complete Dental may contact the company or government program that will be paying for your health care.

**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 a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. By state law, your authorization is valid for 90 days.

**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 you with your healthcare or with payment for your healthcare, 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 (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.

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

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS:

**Restore Complete Dental WANTS YOU TO KNOW YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.**

**Right to Receive This Notice of Privacy Practices** – You have the right to receive a paper copy of this notice at any time. You may obtain a copy of the current notice at any Restore Complete Dental clinic.

**Right to Access:** With few exceptions, you have the right to review and receive a copy of your health information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in **writing** to obtain access to your health information. To receive a copy of your record, please call your local Restore Complete Dental clinic. The office will provide you with the necessary forms and assistance. You may also request access by sending us a letter to the address at the end of this Notice. Radiographs (x-rays) will be duplicated at a reasonable fee of no more than \$10.00.

**Right to Request Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Right to Request Confidential 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.

**Right to Amend:** You have the right to request that Restore Complete Dental amend your health information if it is not correct or complete. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on a Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Privacy Officer: Mayra Barrientos 10901 Garland Rd, Dallas, TX 75218 Telephone: 214.707.9120 Fax: 972.573.2675**



# Restore Complete Dental

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*You may Refuse to Sign This Acknowledgement

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Date

I, \_\_\_\_\_, acknowledge that I have received a copy of this  
(Signature of Patient **OR** Parent /Legal Guardian)  
office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available  
to me to receive.

I, \_\_\_\_\_, consent to the use and disclosure of my personal  
(Signature of Patient **OR** Parent/ Legal Guardian)  
health information by your office for treatment, billing/payment, and healthcare operations as outlined in the  
NOTICE OF PRIVACY PRACTICES.

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### For Office Use Only

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

- Individual refused to sign
  - Witness Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): \_\_\_\_\_