

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonable practicable after the delivery of such treatment;
- If we are required by law to provide and we attempt to obtain such consent but are unable to obtain such consent; or
- If we attempt to obtain consent but are unable to do so due to substantial barriers to communicate with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of benefit to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office.

- The right to reasonable request to receive confidential communications of protected health information from us by alternative means.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of May 23, 2007 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. You may request a written copy of a revised Notice of Privacy practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

Please contact us for more information:

D. Greg Seal, DDS, P.C.
6010 Sherry Lane
Dallas, TX 75225

Attn:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health (202) 619-0257
& Human Services Toll free: (877) 969-6755
Office of Civil Rights
200 Independence Avenue, S. W.
Washington, D.C. 20201

D. Greg Seal, D.D.S., P.C.
6010 Sherry Lane
Dallas, TX 75225
214-361-0883

**Notice of Privacy Practices
Acknowledgment of Receipt Form**

Your signature below indicates that you have been offered a copy of our Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call our office at 214-361-0883.

I have been offered the Notice of Privacy Practices.

Patient Signature Date

Print Patient Signature Date

Legal Guardian or Patient Representative Signature Date

Print Legal Guardian or Representative Name Date

If there is an individual or individuals that you would like to grant access to your account, please complete the section below

Print Name Date

Print Name Date

Print Name Date

FOR OFFICE USE ONLY:

D. Greg Seal, D.D.S., P. C. will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling and or unable to sign this acknowledgment, Dr. Seal must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason: _____

Notice mailed to patient Date: _____ Staff Signature: _____