Joshua Nagao, D.D.S
Designer Dental Group
Notice of Privacy Practices

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.

We are required by law to maintain the privacy of protected information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 9/30/2015, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request. You may request a copy of our Notice at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and examples. Some information, such as HIV-related information, genetic information, alcohol and or/substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

TREATMENT: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you, or to a care provider that is overseeing other health needs you may have.

PAYMENT: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information, or we could require a 3rd party to aid in collection of unpaid balances that are due.

HEALTHCARE OPERATIONS: Health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT: Disclose your health information to your family, friends or any other individual identified by you. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

PUBLIC HEALTH ACTIVITIES: To public health activities, including disclosures to:
Prevent or control disease, injury or disability;
Report child abuse or neglect;
Notify a person who may have been exposed to a disease or condition; or
Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence;

NATIONAL SECURITY: 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 the protected health information of an inmate or patient.

SECRETARY OF HHS: To the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

DISASTER RELIEF: To assist in disaster relief efforts.

WORKER'S COMPENSATION: To the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

REQUIRED BY LAW: When required by federal or state law.

LAW ENFORCEMENT: To law enforcement authorities.

HEALTH OVERSIGHT ACTIVITIES: To an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: To parties and entities in proceeding of the courts and administrative agencies, including in response to a court order or subpoena.

RESEARCH: To researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS: To a coroner or medical examiner. For example, to identify a deceased person, determine the cause of death and to funeral directors consistent with applicable law to enable them to carry out their duties.

OTHER USES AND DISCLOSURE OF PHI: Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

OUR HEALTH INFORMATION RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us for an explanation of our fees for this service.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

RIGHT TO NOTIFICATION OF A BREACH: You will receive notification of breaches of your unsecured protected health information as required by law.

DISCLOSURE ACCOUNTING: With the exception of certain disclosure, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosure of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

RIGHT TO REQUEST A RESTRICTION: To request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

ALTERNATIVE COMMUNICATION: To request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

AMENDMENT: To request that we amend your health information. Your request must be in writing, and it must explain why the information should by amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record and notify you of such. If we deny your request or an amendment, we will provide you with a written explanation of why we denied it and explain you rights.

ELECTRONIC NOTICE: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

QUESTIONS AND COMPLAINTS: If you are concerned that we may have violated your privacy rights, or if 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 may submit a written complaint to the U.S. Department of Health and Human Services. 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.

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act (HIPAA), 2013 Final Rule.

This is to advise you that our office is in compliance with this federally mandated Notice of Privacy Practices law.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

Our Privacy Official:
Tami
1951 N. Wilmot Rd. Bldg 5 Suite 14
Tucson, AZ 85712
officemanager@designerdentaldds.com