

# Notice of Privacy Practices

## Oceanview Dental Multi-Specialty

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

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### 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 01/01/03, 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

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 or 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 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.

**To your Family and Friends:** We must disclose your health information to you, as disclosed 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 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.

**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.

**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.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to an authorized federal official, health information required for lawful intelligence, counterintelligence, and other national security activities.

**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**

**Access:** You have the right to look at or get copies of your health information, with *limited exceptions*. 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**Restriction:** 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).

**Alternative 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.

**Amendment:** You have the right to request that we amend your health information. (Your request must be made 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 our 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 may also 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.

Contact: Oceanview Multi-Specialty Dental Practice

Telephone: (760) 433-0393 Fax: (760) 439-0282

E-Mail: [oceanview@sbcglobal.net](mailto:oceanview@sbcglobal.net)

Address: 2125 El Camino Real Ste 101, Oceanside, CA 92054

# OCEANVIEW DENTAL MULTI-SPECIALTY

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have read and have been offered a copy of this office's  
Notice of Privacy Practices. I understand that by signing this acknowledgement, it will be applicable for  
my entire family and myself.

\_\_\_\_\_

(Please print name)

\_\_\_\_\_

(Family name)

\_\_\_\_\_

(Signature)

\_\_\_\_\_

(Date)

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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, but  
acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency prevented us from obtaining acknowledgement

Other (Please specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# AUTHORIZATION FORM

to communicate treatment

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR 164.508]. It authorizes Oceanview Dental (OVD) to disclose my medical information/treatment/billing-accounting via:

- Voice mail/answering machine
- Mail
- Communication with other parties

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

## OR

Direct communication with myself only – I understand by checking this box it restricts OVD from leaving detailed voice mail messages as well as prohibits OVD from speaking with any family members or friend regarding my treatment or condition.

**\*\*MUST HAVE ACTUAL EXPIRATION DATE\*\*** This authorization expires on \_\_\_\_/\_\_\_\_/\_\_\_\_

Under the Privacy Rules, I have the right to revoke this authorization at any time, and Oceanview Dental may complete any actions it initiated prior to my revocation and which rely on my records for compensation.

I understand that by disclosing my medical information/treatment, Oceanview Dental cannot guarantee the recipient will not use or disclose this information in violation of the Privacy Rules.

I must revoke this authorization in writing and send to Oceanview Dental 2125 S. El Camino Real, Ste 101, Oceanside, CA 92054.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Representative: \_\_\_\_\_ Relation: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_