Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purposes of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information. *
- You have the right to request an alternate means or location to receive communications regarding your health information. *
- You have the right to request in writing to amend, correct, or delete any recorded health information in our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

* *Conditions may apply; obtain additional information from the front desk.*

Changes To This Notice: We reserve this right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

6501 E. Greenway Pkwy,
Suite 161, Building 6
Scottsdale, AZ 85254
480-536-9050

www.scottsdaledentalsolutions.com

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, ____ (Patient), acknowledge that I have received a copy of the Notice of Privacy Practices.

____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

____

Parent or Legal Guardian Date

____

Relationship to Patient

If the patient is not a minor, but under the care of a relative, friend, or caregiver, sign here.

____

Signature Date

____

Relationship to Patient

6501 E. Greenway Pkwy,
Suite 161, Building 6
Scottsdale, AZ 85254
480-536-9050

www.scottsdaledentalsolutions.com