PRIVACY POLICIES

Washougal Family Dental

Please email completed PDF files to: info@washougalfamilydental.com

This notice describes how health information about you may be used and discloses how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

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. This notice takes effect April 14, 2003, 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 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 make 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.

USES AND DISCLOSURE 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 and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your heath 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, we may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it is in affect. 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 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 with your health care 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 an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable references of your best interest in allowing a person to pick up filled prescriptions, medical supplies, xrays, 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. We may disclose your health information to the extent necessary to avert a serious threat to your health safety or the health or safety of others.

My signature indicates that I understand that policies as outlined and any questions I have with regard to privacy policies have been answered.

SIGNATURE OF RESPONSIBLE PARTY OR PATIENT

DATE

If filling out and submitting PDF online: Typed initials, and first name/ last name is sufficient for approval.