KEVIN B. SANDS, DDS
COSMETIC DENTISTRY

HIPAA CALIFORNIA NOTICE FORM

Policies and practices of Dr. Sands' dental practice to protect your health information:

This notice describes how medical and dental information about you may be used and disclosed, and how you can have access to this information.

1. **Disclosures for treatment, payment, and healthcare operation:**

We may use or disclose your protected health information (PHI), for certain treatment, payment, and healthcare operation purposes without your authorization. In certain circumstances we can do so when the person or business requesting you PHI gives us a written request that includes certain promises regarding protecting the confidentiality of your PHI. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment and Payment Operations"
- "Treatment" is when we or another healthcare provider diagnose or treat you. An example of treatment would be when we consult with another health care provider such as your physician or another dentist, regarding your treatment.
- "Payment" is when we obtain reimbursement for our service. An example of payment is when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine your eligibility or coverage.
- " Health Care Operation" is when we disclose you PHI to your health care service plan, (for example, your health insurer), or your other health care providers, contracting with your plan, for administering the plan, such as management and care coordination.
- "Use" applies only to activities within our office, such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.
- "Disclosure" applies to activities outside out office, such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" means written permission for specific use or disclosure.

2. **Use and Disclosures Requiring Authorization:**

We may use your PHI for purposes outside treatment, payment, and health care operation, when your appropriate authorization is obtained. In those instances, when we are asked for information for purposes outside treatment, payment, and health care operation, we will request your authorization prior to forwarding your PHI to them.

3. **Health Oversight:**

If a complaint is filed against us with the California Dental Board, the Board has the authority to subpoena your PHI and dental record relevant to the complaint.

4. **Judicial or Administrative Proceedings:**

If you are involved in a court proceeding and a request is made about the professional services that we have provided to you, we will not release your information without:

a. Your written authorization or authorization of your attorney or personal representative.
b. Court order.
c. A subpoena duces tecum (a subpoena to produce records). When a party seeking records provides our office with a showing that you or your attorney have been served a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block)or modify the subpoena. The privilege does not apply when you are being evaluated for a third party of when the evaluation is court ordered. We will inform you in advance if this is the case.

5. **Workers Compensation:**

If you file a workers compensation claim, we must furnish a report to your employer, incorporating our findings about your injury and treatment, within five days from the date of your initial examination, and at subsequent intervals as may be required by the administrative director of the Workers Compensation Commission, in order to determine your eligibility for workers compensation.

I hereby authorize the use or disclosure of my protected health information as described below. I understand and acknowledge the following:

I am authorizing my protected health information to be used or disclosed as permitted by Federal Privacy Regulation.

- I may inspect or receive a copy of my personal health information.
- My Doctor will not condition my treatment or payment for my treatment on obtaining this authorization form me.
- I have the right to revoke this authorization at any time. My revocation must be in writing and submitted to my doctor. My revocation will not affect any prior action taken by my doctor on reliance on my authorization.

Patient _____ Date _____
Signature

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