# NOTICE OF PRIVACY PRACTICES-HIPAA

***Disclosure of Health Information***

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails or letters).

***Patients' Rights***

***Access:*** You have the right to look at or get copies of your child's health information. If you request copies of your child's records we will make copies for you at no charge.

***Restriction:*** You have the right to request that we place additional restrictions on our use or disclosure of information.

***Alternative Communication****:* You have the right to request that we communicate with you about your child's health history in alternative means.

***Amendment****:* You have the right to request that we amend your child's health information. We may deny your request under certain circumstances.

***Questions and Complaints***

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your child's health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact us.

***Non-Guardian Consent***

I give my permission for the following person(s) to accompany my child to his/her dental visits. **All person(s) listed below must be over the age of 18**. This includes making decisions regarding treatment that may arise during the scheduled appointment. This also gives Dr. Hubbard and her staff permission to discuss treatment and conditions with the person(s) listed below. I understand that I am responsible for payment at the time of services and should someone accompany my child other them myself, arrangements for payment must be made before the scheduled appointment time.

| Name of person bringing the patient: | Relationship to the patient: |
|---|---|
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

Patient's Name (Print): ______________________________________________

Parent/Guardian Signature: ____________________________ Date: ______________