ADAM R. PERSHING, DMD
2300 N. CRAYCROFT RD #4
TUCSON, AZ 85712
520-722-2992

HIPAA PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

-Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
-Obtain payment from third-party payers for my health care services
-Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

*******I authorize _____ to receive information on myself and my account/patient account; i.e., account balances, insurance information, scheduling appointments, appointments dates in the future, dental health information, referral information and referral doctor names, etc.**

Patient Name:_____Date:_____

Signature:_____

Authorized persons relationship to patient:_____

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TUCSON, ARIZONA 85712
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Notice of Privacy Practices

To Our Patients: This notice describes how health information about you, as a patient of this office, may be used and disclosed, and how you can get access to your health information. Please read carefully.

We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide you with notice of our legal duties and privacy practices with respect to PHI. We will not use or disclose your PHI without your written consent, except as described or otherwise permitted by this notice. We reserve the right to change our practices and this notice and to make the new notice effective for all PHI we maintain. Upon request, we will provide any revised notice to you.

Routine uses and Disclosures of Protected Health Information for Treatment and Payment

We are permitted under federal law to use and disclose PHI without your specific permission for routine treatment and payment. Your PHI may be used and disclosed by the employees of this office that are involved in your care and treatment. Your PHI may be used and disclosed as in writing your prescriptions, and dictated treatment information; as well as for payment purposes in which we communicate your PHI to your insurance company so it may process payment for treatment.

Other Uses and Disclosures of Protected Health Information Permitted or Required to Make Without your Authorization

Public Health: To public authorities and health oversight agencies that are authorized to collect information
Judicial and Administrative Proceedings: Lawsuits and similar proceedings in response to a court or administrative order.
Law Enforcement: We may disclose your PHI when required to do so by a law enforcement official.
To Avert a Serious Threat to Health or Safety: When necessary to reduce or prevent a serious threat to your health or safety or the health and safety of another individual or public health.
Military and Veterans: If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
Correctional Institution: To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
Worker's Compensation: For Worker's Compensation and similar programs.
Other Uses and Disclosures: We will obtain your written authorization before using or disclosing your PHI for purposes other than those provided for above (or otherwise permitted by law). You may revoke an authorization in writing at any time.

Your Rights Regarding Your Health Information

You can request that our office communicate with you about your health and related issues in a manner that is convenient for you. You can request a restriction in our use or disclosure of your health information to only certain individuals. We are not required to agree to your request: however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. You have the right to request health information that may be used to make decisions about you including medical records and x-rays. To do so you must submit your request in writing. You may also request in writing to have your information amended if you think it to be incorrect or incomplete.

You may obtain a copy of this notice by contacting our office at 520-722-2992. If you believe your rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.