



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

How We Will Use or Disclose Your Health Information

TREATMENT. We will use your health information for treatment. For example, information obtained by the orthodontist or other members of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We may disclose your health information to your dentist or another specialist providing treatment to you.

PAYMENT. We will use your health information for payment. For example, a bill may be sent to you or your health plan. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

HEALTH CARE OPERATIONS. We will use your health information for our regular health care operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

BUSINESS ASSOCIATES. We may enter into contract with persons or entities known as business associates that provide services to or perform functions on our behalf. Examples include our accountants, consultants, and attorneys. We may disclose your health information to our business associates so they can perform the job we have asked them to do, once they have agreed in writing to safeguard your information.

NOTIFICATION. We may use or disclose information to assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition. If we are unable to reach your family member or personal representative, then we may leave a message for them at the phone number that they have provided to us, e.g., on an answering machine.

INDIVIDUALS INVOLVED WITH YOUR CARE OR PAYMENT FOR YOUR CARE. We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

APPOINTMENT REMINDERS / HEALTH BENEFITS. We may contact you to provide appointment reminders or information about treatment alternatives or other health benefits that may be of interest to you.

FUNERAL DIRECTORS AND CORONERS. We may disclose your health information to funeral directors, and to coroners or medical examiners, to carry out their duties consistent with applicable law.

FUNDRAISING. We may contact you as part of our fundraising efforts; however, you may opt-out of receiving such communications.

WORKERS' COMPENSATION. We may disclose health information to the extent authorized by and to the extent necessary, to comply with laws relating to workers' compensation or other similar programs established by law.

RESEARCH. We may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may also disclose your health information to people preparing to conduct a research project, so long as the health information is not removed from us. We may also use and disclose your health information to contact you about the possibility of enrolling in a research study.

PUBLIC HEALTH ACTIVITIES. As required by law, we may disclose your health information for public health activities, including disclosures to: (i) prevent or control disease, injury, or disability; (ii) report child abuse or neglect; (iii) report reactions to medications or problems with products or devices; (iv) notify a person of a recall, repair, or replacement of products or devices; (v) notify a person who may have been exposed to a disease or condition; or (vi) notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

HEALTH OVERSIGHT ACTIVITIES. We may disclose your health information to health oversight agencies for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

REQUIRED BY LAW. We may disclose your health information when we are required to do so by law.

525 Pleasant Home Road
Augusta, Georgia 30907
706-860-2442

4101 Amberley Trail
Evans, Georgia 30809
TrotterOrthoAugusta.com



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American
Association of
Orthodontists®

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JUDICIAL AND ADMINISTRATIVE PROCEEDINGS. We may disclose your health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

LAW ENFORCEMENT PURPOSES / NATIONAL SECURITY. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of an inmate or patient. We may disclose your health information for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

The following uses and disclosures will be made only with your authorization: (i) with limited exceptions, uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in this notice. You may revoke your authorization at any time in writing, except to the extent that we have taken action in reliance on the use or disclosure indicated in the authorization.

Your Health Information Rights

Although your health record is the physical property of this office, you have the following rights with respect to your health information:

- You may request that we not use or disclose your health information for a particular reason related to treatment, payment, our general healthcare operations, and/or to a particular family member, other relatives or close personal friend. We ask that such requests be made in writing on a form provided by us. Although we will consider your request, please be aware that we are under no obligation to accept it or to abide by it, except as provided below.
- If you have paid for services out-of-pocket in full, you may request that we not disclose information related solely to those services to your health plan. We ask that such requests be made in writing on a form provided by us. We are required to abide by such a request, except where we are required by law to make a disclosure. We are not required to inform other providers of such a request, so you should notify any other providers regarding such a request.
- You have the right to receive confidential communications from us by alternative means or at an alternative location. Such a request must be made in writing, and submitted to the Privacy Officer. We will attempt to accommodate all reasonable requests.
- You may request to inspect and/or obtain copies of health information about you, which will be provided to you in the time frames established by law. If we maintain your health information electronically in a designated record set, you may obtain an electronic copy of the information. If you request a copy (paper or electronic), we will charge you a reasonable, cost-based fee.
- If you believe that any health information in your record is incorrect, or if you believe that important information is missing, you may request that we correct the existing information or add the missing information. Such requests must be made in writing, and must provide a reason to support the amendment. We ask that you use the form provided by us to make such requests. For a request form, please contact the Privacy Officer.
- With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
- You have the right to be notified following a breach of your unsecured protected health information.
- You have the right to obtain a paper copy of our Notice of Privacy Practices upon request.

Questions and Complaints

You have the right to complain to us and to the Secretary of the U.S. Department of Health and Human Services (HHS) if you believe we have violated your privacy rights. We will not retaliate against you for filing a complaint.

For more information or to file a complaint with us, contact our Privacy Officer by phone or mail as follows:

Laura Ware, (706) 860-2442, 525 Pleasant Home Road, Augusta, GA 30907

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

If you have any questions or want more information about this Notice of Privacy Practices, please contact our Privacy Officer.

ACKNOWLEDGEMENT OF RECEIPT:

Acknowledged By: _____
Signature of Patient, Guardian or Personal Representative

Date: _____

Printed Name: _____