Franklin C. Lackee, DDS

419 East Main Street, Suite 202, Middletown, NY 10940
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NOTICE OF PRIVACY PRACTICES (HIPAA)

Protecting Your Confidential Health Information is Important to Us

** THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION **

Dear Patient:

Our Promise

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA-Health Insurance Portability & Accountability Act)
We will use and communicate your Health Information only for the purposes of providing your treatment, obtaining payment, conducting health care operations and as otherwise described in this notice.
Federal law generally permits us to make certain uses or disclosures of health information without permission. Federal law also requires us to list in the notice each of these categories of uses or disclosures.

As Required by Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in the court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are victim of abuse, neglect or domestic violence (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to work only with companies with a similar commitment to the security of your health information.

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Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your **treatment, medications, transportation, or payment**. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care. If this form is being filled out for your child, this includes anyone who would be bringing them to or picking them up from their appointments.

Please list the name(s) of the person (people) we may discuss treatment and the account with:

_____ _____

_____ _____

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mail communications that are sealed. We will honor your reasonable requests for confidential communications.

Can we leave a message on cell phone or home phone? (Please circle answer):

Yes No Initials _____.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail you a copy.

Changes to this Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our notice.

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form below.

_____ _____

Patient Signature (parent *or* guardian if under 18 years of age) **Date (mm/dd/yyyy)**