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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

At Turquoise Dental Group, we have always kept your health information secure and confidential.
A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist, who may be involved in your care.

We may use or disclose your health information for payment of our services. For example we may send a report of your treatment to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have written contract with each business associate that require them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave information on your answering machine or with the person that answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all your health information when required by law.

If this practice is sold, your information will become the property for the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see.

You have the right to receive a copy of this notice, we will notify you of the changes in writing.

Acknowledgement

I have read the Notice of Privacy Practice

Print Name_________________________________ Sign_______________________________

Parent or Guardian_____________________________ Date____________________________