

Cornerstone Assistance Network Dental Clinic

HIPAA 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.

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 your individual identifiable health information is protected by federal law. This notice describes the privacy practices of Cornerstone Network Assistance – Dental Clinic. When you receive treatment at Cornerstone Network Assistance – Dental Clinic we create and maintain information about your health and dental treatment. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information collected without your authorization for dental treatment and healthcare operation purposes (i.e. name, date of birth, phone/fax numbers, email addresses, home address, social security number and demographic data). Examples include but are not limited to:

- Using or sharing your health information with other health care providers involved in your dental treatment, services or continuity of care.
- With a pharmacy that is filling your prescription.
- For health care operations and oversight activities necessary to run our practice.
- When a law requires the use of disclosure.
- To provide appointment reminders by phone call, voice message or text message.
- With our contractual business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information according to agency standards.
- For public health activities such as reporting diseases to a public health authority authorized to receive this information, or to report medical device issues to the FDA.
- To alert authorities about abuse, neglect, or domestic violence.
- For health oversight activities such as audits, investigations or inspections.
- For judicial and administrative proceedings such as responding to a subpoena or other lawful order.
- For law enforcement purposes such as identifying or locating a suspect or missing person.
- To coroners, medical examiners, or funeral directors pertaining to their job duties.
- To avert a serious threat to health or public safety.
- For specialized government functions such as law enforcement custodial situations (CPS).
- For incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential.
- As otherwise required or permitted by local, state or federal law.

Any other services or disclosure of your protected health information will be made only after obtaining your written authorization. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization.

YOUR PRIVACY RIGHTS

You have the following rights with respect to certain health information in your dental treatment record. To exercise any of these rights, you must submit a written request to our Privacy Official at:

Cornerstone Assistance Network - Dental Clinic
Attn: Dental Clinic Manager
3500 Noble Ave.
Fort Worth, Texas 76111
817-632-6018
817-632-6026

Under these privacy rules, you have the right to:

- A paper copy of this notice.
- Request restrictions on the use and disclosure of your protected health information.
- Request confidential communication of your protected health information.
- Inspect and obtain copies of your protected health information upon written request.
- Amend or modify your protected health information if you believe your health information is incorrect or incomplete.
- Receive an accounting of certain disclosures made by us for your protected health information.
- Receive notification if the privacy or security of your health information has been breached.
- You may, without risk of retaliation, file a complaint as to any violation by us or your privacy rights with us (by submitting inquiries to our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

Our Duties and Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it.

We have the following duties under the HIPAA Privacy rules:

- By law, to maintain the privacy of protected information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information.
- To abide by the terms of our Privacy Notice that is currently in effect.
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.
- To limit access to your protected health information to those in direct patient care and what is “minimally necessary” to complete your dental treatment.

We are obligated under the HIPAA Privacy rules to:

- Honor any request by to you restrict the use of disclosure of your protected health information.
- Amend your protected information if, for example, it is incorrect or incomplete.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients or third parties.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

**Cornerstone Assistance Network
Dental Clinic
3500 Noble Avenue
Fort Worth, Texas 76111**

Acknowledgement	This notice is effective the date of your signature.
<p>I, _____, hereby acknowledge that I have received and reviewed a copy of Cornerstone Assistance Network – Dental Clinics <i>HIPAA Notice of Privacy Practices</i>.</p> <p>I understand that Cornerstone Assistance Network – Dental Clinics <i>HIPAA Notice of Privacy Practices</i> may change periodically and that I am entitled to receive a copy of Cornerstone Assistance Network – Dental Clinics revised <i>HIPAA Notice of Privacy Practices</i> upon request.</p> <p>I understand that, if I have questions about Cornerstone Assistance Network – Dental Clinics <i>HIPAA Notice of Privacy Practices</i>, I may contact the Dental Clinic Manager at 817-632-6018.</p> <p>I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Cornerstone Assistance Network – Dental Clinics will not refuse treatment to me if I refuse to sign this Acknowledgement.</p> <p>I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Cornerstone Assistance Network – Dental Clinics privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the Dental Clinic Manager, noted above, for assistance.</p>	
_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative

	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY		
<p>Cornerstone Assistance Network – Dental Clinics made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its <i>HIPAA Notice of Privacy Practices</i>. In spite of these efforts, Cornerstone Assistance Network – Dental Clinics was unable to obtain a signed Acknowledgement for the following reason(s):</p> <p><input type="checkbox"/> Refusal to sign Acknowledgement on _____, 20____.</p> <p><input type="checkbox"/> Communications barriers prohibited us from obtaining a signed Acknowledgement.</p> <p><input type="checkbox"/> An emergency situation prohibited us from obtaining a signed Acknowledgement.</p> <p><input type="checkbox"/> Other (Describe): _____</p>		
Date Received	By	Patient ID