Rocky Mountain Dental Care

1027 Robertson Street • Fort Collins, CO 80524 - Leslie Johnson, DDS

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 it carefully.

At Rocky Mountain Dental Care we have always kept your health information secure and confidential. HIPPA law requires us to maintain your privacy and to give 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.

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

We may use or disclose health information for normal healthcare operations. For example, staff will enter your information into the computer. We may share medical information with business associates, such as a billing service, but we maintain a contract with each of these requiring them to protect your privacy just as we do.

We may use your information to contact you. For example, we may send reminders tor your appointments. We may also leave appointment information with a person, or on your answering machine should you not be available.

We may release your information when required by law.

If this dental practice is sold, your information will be given to the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. It you request a copy of your records, this must be done in writing and a reasonable fee may be charged.

Our HIPPA Privacy book is available tor you to review, should you request it. This notice has been in effect since April 14, 2003.

Acknowledgement:

I have read this notice of Leslie G. Johnson, DDS Notice of Privacy Practices and give my consent.

Patient (or guardian) Printed Name: _____

Signature: _____ Date: _____

Patient (or guardian) Printed Name: _____

Signature: _____ Date: _____

Patient (or guardian) Printed Name: _____

Signature: _____ Date: _____

Patient (or guardian) Printed Name: _____

Signature: _____ Date: _____