

# Dr. Katherine A. Kelly

ORTHODONTICS

1020 E. Michigan Avenue, Suite E  
Saline, MI 48176  
734-429-7676



## **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.**

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation require that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

### **Who Will Follow This Notice**

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

### **How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we may use and disclose medical information without your specific consent of authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

#### **For Treatment**

We may use medical information about you to provide you with medical treatment or services. Example: in treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

#### **For Payment**

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

#### **For Health Care Operations**

We may need and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

### **Other Uses or Disclosures That Can Be Made Without Consent or Authorization**

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Our healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPPA)
- Uses and disclosures required by law
- Uses and disclosures in domestic violence or neglect situations
- Health oversight activities
- Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  1. The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  2. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  3. The right to receive confidential communications of protected health information.
  4. The right to inspect and copy protected health information.
  5. The right to receive an accounting of disclosures of protected health information.
  6. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide to me a revised Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_