



OTTAVIANO
DENTAL

HIPAA NOTICE OF PRIVACY PRACTICES

(Privacy Notice + Acknowledgment)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At **Ottaviano Dental** we are committed to protecting the privacy of your protected health information (“PHI”) in accordance with federal and state law, including HIPAA regulations.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

Treatment

We may use and disclose your information to provide, coordinate, or manage your dental care. Included but not limited to: Referring you to a specialist, sending x-rays or records to another provider, and discussing treatment with laboratories.

Ottaviano Dental

107 Monmouth Road, Suite 107, West Long Branch, NJ, 07764

P: (732) 389-1110



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Payment

We may use your information to bill and collect payment for services rendered. Included but not limited to submitting insurance claims, verifying insurance benefits, and collecting outstanding balances

Healthcare Operations

We may use your information for normal business operations. Included but not limited to quality assessment, employee training, appointment reminders, and audits and compliance reviews.

OTHER PERMITTED DISCLOSURES

We may disclose your information when required or permitted by law, including but not limited to: public health reporting, law enforcement requests, judicial proceedings, workers' compensation claims, and preventing serious threats to health or safety.

COMMUNICATIONS

We may contact you by: Phone, Voicemail, Text message, and Email for appointment reminders, treatment information, and billing communications unless you request otherwise.

YOUR RIGHTS

You have the right to: Request restrictions on disclosures, request confidential communications, Inspect or obtain copies of records, request corrections to records, receive an accounting of disclosures, and obtain a paper copy of this notice.

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OUR RESPONSIBILITIES

We are required by law to: Maintain the privacy of your information, provide this notice, follow the terms of this notice, and notify you in the event of a breach involving unsecured protected health information

QUESTIONS OR COMPLAINTS

If you believe your privacy rights have been violated, you may contact our office or file a complaint with the U.S. Department of Health and Human Services.

We will not retaliate against you for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices from **Ottaviano Dental**

Patient Name: _____

Signature: _____

Date: _____

If signed by representative:

Representative Name: _____

Relationship to Patient: _____

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**AUTHORIZATION TO RELEASE / DISCUSS HEALTH
INFORMATION**

(HIPAA Release Form)

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone Number: _____

AUTHORIZATION

I authorize **Ottaviano Dental** discuss and/or release my protected health information, including appointment information, treatment plans, billing information, insurance information, claims status, radiographs, prescriptions, and dental records to the following individual(s):

Authorized Person #1

Name: _____

Relationship: _____

Phone Number: _____

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Authorized Person #2

Name: _____

Relationship: _____

Phone Number: _____

Authorized Person #3

Name: _____

Relationship: _____

Phone Number: _____

COMMUNICATION PREFERENCES

- Leave voicemail messages regarding appointments or treatment
 - Leave billing or insurance information on voicemail
 - Send text appointment reminders
 - Send email communications
-

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DURATION OF AUTHORIZATION

This authorization shall remain in effect:

Until revoked by me in writing

One year from signature date

Other: _____

PATIENT RIGHTS

I understand that:

- I may revoke this authorization at any time in writing.
 - Revocation will not apply to information already released before the revocation was received.
 - My treatment or payment eligibility will not be affected if I choose not to sign this authorization.
 - I have received or been offered a copy of the Notice of Privacy Practices.
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SIGNATURE

Patient/Legal Representative Name: _____

Signature: _____

Date: _____

Relationship to Patient (if not patient): _____

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