NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Island Dental is required by federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of Privacy Practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

You have the right to review our privacy practices, the right to access any health information or amendments made to it. You also have the right to an accounting of disclosures and restrict uses of communicating health information.

We may use and disclose health information about you for treatment, payment, and health care operations (which does include communication with your dental specialist or physician).

We will not use your health information for any manner of direct or indirect personal gain or other unauthorized use.

We may use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect or domestic violence or the possible victim of other crimes.

We will not use or disclose your health information for any reason other than those listed without your written authorization.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. For more information about our privacy practices, please contact our office manager at 480.507.9400.

I have read and understand the privacy practices of Island Dental. I consent for Island Dental to disclose my protected health information as described.

In addition to our use of our health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

___ I authorize the use of my health information for any other purpose other than what is stated in the Notice of Privacy Practice.

___ I Do Not authorize the use of my protected health information for any other purpose other than what is stated in the Notice of Privacy Practice.

_______________________________ Signature of Patient or Guardian

_________________ Date