SUNRISE DENTAL
www.sunrisedental.com

# Statement of Privacy Practices
## Sunrise Dental

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

## Protecting your personal health care information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentially of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

## Collecting protected health information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

## Disclosure of your protected health information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

## Patient rights

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately.
We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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## Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Sunrise Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties to this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Sunrise Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

| | | |
|---|---|---|
| ANY MEMBER OF MY IMMEDIATE FAMILY | YES | NO |
| SPOUSE ONLY | YES | NO |
| OTHER (PLEASE SPECIFY) | YES | NO |

Name of Patient or Responsible Party

Signature of Patient or Responsible Party

Date

Description of Responsible Party's Authority

**OFFICE USE ONLY BELOW THIS LINE**

**RECORD OF ACKNOWLEDGEMENT NOT OBTAINED**

Provided prior to treatment? Yes No

Date Provided:

Reason for Denial:

Needed more time to review statement of Privacy Practices.
Wanted to consult with another person, before signing.
Unable to sign.
Reason not given.
Other (explain):