

STATEMENT OF PRIVACY PRACTICES

CHAISSON & CHAISSON, DDS, PLLC

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE 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 health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. 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 confidentiality, integrity, and access to 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 HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), 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 HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a 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. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

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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 Chaison & Chaison, DDS, PLLC. 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 of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Chaison & Chaison, DDS, PLLC reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

| | | |
|--|------------------------------|-----------------------------|
| Spouse only | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| OR | | |
| Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any Member of my extended family: (i.e. Parents, Grandchildren) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Other: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Name of patient (please print): _____

Patient signature: _____

Patient's personal representative: (Please Print): _____

Personal Rep's signature: _____

Representative's Phone Number: _____

Date: _____

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

| Provided Prior to Treatment? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Date Statement Provided: |
|---|------------------------------|--|--------------------------|
| Reason for not obtaining patient signature | <input type="checkbox"/> | Needed more time to review Statement | |
| | <input type="checkbox"/> | Wanted to consult another person before signing | |
| | <input type="checkbox"/> | Physically unable to sign | |
| | <input type="checkbox"/> | No reason offered | |
| | <input type="checkbox"/> | Other: | |