**Statement of HIPAA Privacy Policies**
**Oral Surgery Associates of Paris**
**3110 Lamar Ave Paris TX 75460**

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 not be compromised. We may, from time to time, amend our privacy policy 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 Texas. 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 chose, for any purpose.

Our office and electronic systems are secure from unauthorized access. Your privacy policy and practices apply to all former, current and future patients so you can be confident that your protected health information will ever improperly be disclosed or released.

**Collecting Protected Healthcare Information (PHI)**
We will only request personal information needed to provide our standard quality of health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, phone numbers, SSN, employment data, medical history and health records. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of 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 required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing or fundraising purposes without your consent. We may use and disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, unless you direct us otherwise. We will never use, disclose, sell or otherwise allow access to your personal, protected information in exchange for receipt of financial remuneration.

Any breach in the protection of your PHI, 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 PHI.

**Your Rights As Our Patient**
You have a right to request copies of your healthcare record, to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have displosed your PHI for use other than stated above. All such requests must be in writing. We will charge a fee for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify the US Department of Health and Human Services.

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

**Acknowledgement Of Receipt of Statement of Privacy Practices**

I acknowledge that I have received a copy of the Statement of Privacy Practices. 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 is also posted in this facility.

Oral Surgery Associates of Paris reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised policies at the time of my first visit after the revisions become effective. I may also obtain a revised statement mailed 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 PHI to the person (s) identified below.** I understand that the default answer is NO without indicating YES in answer to each individual question. PHI cannot be shared with anyone unless otherwise by HIPAA rules.

| | | |
|---|---|---|
| Spouse Only _____ | Y | N |
| Any member of immediate family (Children, Siblings) | Y | N |
| Other: (Please Specify) _____ | Y | N |

**Please Sign Below Indicating Review of Policies**

Name of Patient _____

Patient Signature _____

Patient's Personal Representative _____

Personal Representative Signature _____

Representatives Phone Number _____

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**Office Use Below Only**

Acknowledgement Not Obtained

Provided Prior to Treatment? Y N Date Provided:

Reason for not obtaining signature

___ Need more time to review
___ Wanted to consult another person
___ Physically unable to sign
___ No reason offered
___ Other: _____