

ROBIN F. GALLAGHER
D.M.D., M.A.E.S.

825 Bethlehem Pike, Suite 200
Flourtown, PA 19031



CHESTNUT HILL
DENTAL

ph: 215.242.6404
email: contact@chestnuthilldental.org
web: chestnuthilldental.org

Chestnut Hill Dental-HIPAA Privacy Form 1 Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

We are required by applicable federal law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. 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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. We use and disclose health information about you for: treatment, payment, and healthcare operations. Your authorization: In addition to our use of your 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. We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may use or disclose health information to notify a family member, or another person responsible for your care, of your location, your general condition, or death. We may use or disclose your health information when we are required to do so by law. We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters). You have the right to look at or get copies of your health information. A fee will be applied for all copies of records. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. We are committed to safe, quality dental care. If you have a special need, or want more information about the privacy policy, please contact Mrs. Cindy Dowling in our office. Refused to Sign (check here and initial): _____

Employee Initials: I authorize disclosure of my health information to the following:

Patient Signature for Authorization of Disclosure: _____

Date: _____

Patient Signature for Revocation of Disclosure: _____

Date: _____