AppleWhite Dental Iowa. P.C., dba
UNIVERSITY DENTAL GROUP
4626 University Avenue
Des Moines, IA 50311

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. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your health information. We are required by law to maintain the privacy of your health information and provide you this Notice describing our legal duties and privacy practices.

This Notice of Privacy Practices describes how we will use and disclose protected information and data that we receive or create related to your healthcare. This notice also describes the rights you have concerning your own health information. We must, follow the obligations described in this notice and are required by law to notify you following a breach of privacy of your health information.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately, as discussed below. Patient records will not be available to persons other than CORDENTAL Group employees. We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We will use and disclose your health information while providing, coordinating or managing your health care. We may also disclose your health information to other who need that information to treat you, such as dentists, hygienists, specialists or other providers or facilities involved in your care. We may also use and disclose your health information to contact you to provide treatment-related services, such as treatment options or alternatives or to tell you about other health-related benefits and services that may be of interest to you.

Payment: We may use and disclose your health information to obtain or provide compensation or reimbursement for providing your health care. For example, we may send a bill to you or to your health plan. Your health plan or health insurance company may ask to see parts of your health information before they will pay us for your treatment.

Health Care Operations: We may use your information to run our organization, improve your care and contact you when necessary.

Notification of Family and Others Involved in Your Care: Unless you object, we may disclose your health information to a family member or personal representative who is involved in your healthcare, or to someone who helps to pay for your care. If a person has legal authority to make health care decisions for you, we will treat that representative the same way we would treat you with respect to your health information

Payment: We may use and disclose your health information to insurers and health plans to get paid for the treatment and services we provided to you. E.g., your health insurance company may ask to see parts of your health information before they will pay us for your treatment.

Business Associates: We may disclose your health information to our third-party service providers ("Business Associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All Business Associates ore obligated, under contract, to properly safeguard health information and are not allowed to use or disclose any information other than as specified in our contract.

Required by Law: Federal, state or local laws sometimes require us to disclose patients' health information. For instance, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with federal laws governing the privacy of health information. We also are required to give information to Worker's Compensation Programs for work-related injuries.

Public Health Activities: We may report certain health information for public health purposes. For instance, we may need to report adverse reactions to medications or medical products to the U.S. Food and Drug Administration.

Public Safety: We may disclose health information for public safety purposed in limited circumstances. We may disclose health information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose health information for other law enforcement purposes as permitted by law.

Health Oversight Activities: We may disclose health information to a government agency that oversees our company or its personnel to allow the agency to provide appropriate oversight of the health care system, government benefit programs, and civil rights laws.

Coroners, Medical Examiners, and Funeral Directors: We may disclose information concerning deceased patients to coroners, medical examiners, and funeral directors to assist them in carrying out their duties.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your health information as required by military command authorities or to the Department of Veterans Affairs. We may also disclose health information to federal officers for intelligence and national security purposes or for presidential protective services.

Judicial Proceedings: We may disclose health information if ordered to do so by a court or if a subpoena or search warrant is served.

Marketing/Sale of Information: We will never sell your information or share your information for marketing purposes unless you give us written permission. If we contact you for any fundraising efforts, you can ask that we not contact you again.

Psychotherapy Notes: We will obtain your prior authorization for most uses and disclosures of psychotherapy notes, except for those uses and disclosures expressly permitted under law.

WRITTEN AUTHORIZATION FOR ANY OTHER USE OR DISCLOSURE

Your authorization is required if we wish to use or disclose your health information for a purpose that is not discussed in this notice or is otherwise permitted or required by law. You may revoke such an authorization at any time, unless we have already relied on your authorization to use or disclose information. If you would ever like to revoke your authorization, please notify us in writing.

RESTRICTIONS ON DISCLOSURE OF PHI TO HEALTH PLANS

At your request, we will not disclose your information to your health plan if the disclosure is for payment or health care operations an pertains to a health care item or service for which you have paid out of pocket in full.

YOUR INDIVIDUAL RIGHTS

Right to Request Your Health Information - You have the right to look at your own health information and to get a copy of that information, unless otherwise restricted by law. A fee may be charged for the expense of fulfilling your request and we will tell you in advance what these charges will be. We may deny your request in certain limited circumstances. If you are denied access to your health information you may request that the denial be reviewed.

Right to Request Amendment - If you examine your health information and believe that it is wrong or incomplete, you may ask us to amend your record. Requests to amend your health information must be submitted by writing to the address below. We may deny your request under certain circumstances, but we will respond to your request with an explanation within sixty (60) days.

Right to Get a List of Disclosures of Your Health Information - You have the right to request a list of the disclosures we make of your health information. Your request must state a time period, which may not go back further than six (6) years and must be made in writing to the address below. A fee may be charged for more than one request per year. We will tell you in advance what these charges will be.

Right to Request Restrictions - You have the right to ask us NOT to make uses or disclosures of your health information to treat you, to seek payment for care, or to operate our systems. If you would like to request a restriction, you must do so in written detail to the address below. We are not required to agree to your request.

Right to Request Confidential Communications - You have the right to receive confidential communication of your health information in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. Requests must be made in written detail at the address below. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways and locations you request, we may contact you using other information we have.

Right to be Notified Following a Breach or Unsecured PHI - You will be notified of any breaches of your unsecured protected health information as require by law.

Right to Choose a Representative - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure this person has the authority and can act for you before we take any action.

Right to Receive Notice - You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive the Notice electronically. Requests must be submitted in person or in writing to the address below.

CHANGES TO THIS NOTICE

From time to time, we may change our practices concerning how we use or disclose patient health information, or how we will implement patient rights concerning their information. We reserve the right to change this notice and to make the provisions in our new Notice effective for all health information we maintain. If we change these practices, we will post a revised Notice of Privacy Practices. You can get a copy of our current Notice of Privacy Practices at any time by requesting one from the Privacy Officer at the address below.

DO YOU HAVE CONCERNS OR COMPLAINTS?

Please tell about any problems or concerns you have with your privacy rights or how we use or disclose your health information. If you have a concern, please contact us at the address below.

If for some reason we cannot resolve your concern, you may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at 200 Independence Avenue, SE, Washington, DC 20201. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

DO YOU HAVE QUESTIONS?

We are required by law to give you this Notice and to follow the terms of the notice that is currently in effect. If you have any questions about this notice or have further questions about how we may use and disclose your health information, please contact the Privacy Officer.

PRIVACY OFFICER:
Laura Myers, Compliance Director
lauramyers@cordentalgroup.com
(513) 609-4076
9825 Kenwood Road, Ste. 200
Cincinnati, OH 45252

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ACKNOWLEDGEMENT RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for **University Dental Group.** The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Notice of Privacy Practices also describe my rights and the responsibilities and duties of CORDENTAL Group with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

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

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice 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/PARTNER ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY) _____	☐ YES	☐ NO

MY SIGNATURE BELOW ACKNOWLEDGES I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS ACKNOWLEDGEMENT AND/OR CHANGES IN THE ADDITIONAL DICLOSURE AUTHORITY AT ANY TIME.

_____ _____
PATIENT NAME (PRINTED) DATE

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

OFFICE USE ONLY: RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

ACKNOWLEDGEMENT WAS NOT OBTAINED FOR THE FOLLOWING REASON(S):

☐ Needed more time to review Notice of Privacy Practices.
☐ Wanted to consult with another person before signing.
☐ Unable to sign.
☐ Reason not given
☐ Other (please explain) _____

_____ _____
PATIENT NAME (PRINTED) DATE

_____ _____
CORDENTAL GROUP REPRESENTATIVE POSITION