

# PRIVACY NOTICE

RONALD P. KOLODZIEJ, D.M.D., M.S., L.L.C.

***This notice describes how your medical information may be used & disclosed and how you can gain access to it. Please read the entire notice.***

Your protected health information (i.e., individually identifiable information such as names, dates, phone numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by Ronald P. Kolodziej, D.M.D., M.S., L.L.C. (hereafter referred to as “the practice”) in one or more of the following examples:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, x-rays, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally to all staff members who have any role in your treatment and in the training of new staff members;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To occasional observers who are in the dental profession or who are pursuing a dental education but are not officially associated with the practice (other orthodontists, dentists, dental students, other students, etc.) and who are invited on the premises by the practice;
- To any government authority or law enforcement agency when illegal abuse or neglect is suspected or observed, or when required for certain criminal and/or forensic investigations;
- To federal, state or local authorities and agencies when necessary to prevent potential threats to public health and/or national security;
- To your family and/or close friends whom you have involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information related to your treatment or other services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

According to federal privacy regulations, you have the right to:

- Request restrictions on use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information from the practice on request (a fee may be assessed to defray costs of duplication and fulfillment of requests may take up to 30 days);
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by the practice of your privacy rights with the practice (by submitting inquiries to the Privacy Contact Person at the practice's address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

The practice has the following duties under federal privacy regulations:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth the practice's legal duties and privacy protocols with respect to such information;
- To abide by the terms of the practice's Privacy Notice that is currently in effect;
- To advise you of the practice's right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by the practice, and that if the practice does so, the practice will provide you with a copy of the revised Privacy Notice.

Please note that the practice is not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that eliminates the possibility that your protected health information may be incidentally overheard by other patients and third parties.

*This privacy notice is effective as of the date of your signature. If you have any questions about the information in this notice, please ask to speak with the practice's Privacy Contact Person or direct your correspondence to this person at the practice's address.*

## PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

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Patient (or Guardian)

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Date