1. You have the right to revoke or cancel this authorization at any time, except to the extent information has already been shared based on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, submit your request in writing to Lennie, Gentle Dental Family Dentistry's Office Manager, at 3276 West Rd, Trenton, MI 48183.

2. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized our office to disclose information about you to a third party. If you refuse to sign and have authorized our office to disclose information about you to a third party, such as an insurance company, we have the right not to treat you or accept you as a patient in our practice.

3. Once information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. If you revoke this authorization, it will not affect any use or disclosures permitted by your authorization while it was in effect.

4. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our office may deny access if we reasonably believe access could cause harm to you or another individual. If access is denied, you may request a second opinion by a licensed healthcare professional at your expense.

5. You have a right to a copy of this signed authorization in written form.

6. You may be contacted for a variety of purposes using the information you have provided. These include, but are not limited to, appointment information, reminders, and information considered marketing. By signing this Notice, you are agreeing to accept communication from our office on any and all phone numbers, emails, devices, and platforms you have provided for, but limited to, the aforementioned purposes. For any landline or cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and it's service providers may use recorded messages. I agree to be contacted by the means I provide for myself and/or my children.

7. We may use or disclose your health information when we are required to do so by law. We also may disclose your health information in the following circumstances; if we reasonably believe you are a victim of abuse, neglect, domestic violence, or other crimes, to military personnel under certain circumstances, to authorized federal officials when required for national security activities, to correctional institutions or law enforcement officials having lawful custody, to an emergency contact or personal representative in the event of your incapacity or emergency circumstance, in connection with our healthcare operations, and to provide you with appointment reminders.

Rights to Personal Health Records and Disclosures

Access: You have the right to look at or receive copies of your health information with limited exception. You may request copies in a format other than photocopies and we will use your requested format when it is reasonable to do so. Requests for health information must be made in writing and sent to Lennie, Gentle Dental Family Dentistry's Office Manager, at 3276 West Rd, Trenton, MI 48183. You will be charged a reasonable, cost-based fee for expenses incurred while processing your request. You will be charged $35.00 for every request processed and an additional charge for postage if you would like your documents mailed. Another option is to request an explanation or a summary of your health information which will be processed for a fee.

Disclosures: You have a right to an accounting of the disclosures of your protected dental information by our office. The maximum disclosure accounting period is the six years immediately preceding the accounting request. We are not required to provide an accounting of disclosures for treatment, payment, or dental care operations, to you or your personal representative, for notification of or to persons involved in our dental care or payment for dental care, for disaster relief, or for facility directories, pursuant to an authorization, of a limited data set, for national security or intelligence purposes, to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody, or incidents otherwise permitted for required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities. If requested more than once in a 12 consecutive month period, you will be charged a reasonable, cost-based fee.

Restrictions: You have the right to request additional restrictions on our use and disclosures of your health information, however, we are not obligated to agree.

Alternative Communication: You have the right to request we alter our use or disclosure of your health information by changing our means and location of communications. For example, you may request that we send your protected health information to an address that is not your home or call you on a number that is not your landline or cell phone. Requests for alternative communication must be made in writing, specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location.

Amendments: You have the right to request we amend your health information. Your request must be made in writing and explain why the information should be amended. We may deny your request.

QUESTIONS AND COMMENTS

If you would like additional information about our privacy practices, have questions or comments, are concerned we may have violated your privacy rights, or disagree with a decision we made about access, restrictions, alternative communications, or amendments, please contact our office using the information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services, of which we will provide you the address upon request. We will not retaliate if you choose to file a complaint with us or the DHHS.

I understand I can obtain this Notice on request. I understand and agree to the terms outlined in this document. I verify I am at least 18 years old and am the patient/patient's legal guardian.

Patient/Guardian's Signature: _____ Date _____

If signed by a parent/guardian, relationship to patient: _____