Print Form

Scott J. Rosen DMD, LLC
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Richboro, PA 18954
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NOTICE OF PRIVACY PRACTICES

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to a family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provided to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of health professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give is written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health- Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information with limited exeptions. If you request copies, we will charge you $25.00 to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

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Aknowledgment Of Receipt Of Notice Of Privacy Practices

You may refuse to sign this acknowledgement

I,_____, have received a copy of this office's Notice Of Privacy Praactices.

_____
Please print name

_____
signature

_____
date

For Office Use Only

We attempted to obtain Written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign

( ) Communication barriers prohibited the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please specify)

_____

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