NOTICE OF PRIVACY PRACTICES
For the Office of Dr. Michael H. Connor d/b/a Orlando Periodontics and Implants

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY

We have always kept and will continue to keep your health and personal information secure and confidential. The Health Insurance Portability and Accountability Act of 1996 is a federal program that requires that all medical records and other individually identified health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential has been revised in 2013 (HIPAA). This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. This information includes your full legal name, your address, social security number, proposed and past treatment.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your personal and health information and how we may use and disclose your personal and health information.

The law permits us to use or disclose your health information to those involved in your treatment. Treatment means providing, coordinating, or managing details about your health and related services by one or more health care providers. This may include your General Dentist and your medical health care providers such as General Physician, Cardiologist, Endocrinologist, Internist, etc. This information may be disclosed electronically, on paper or orally.
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We may use and disclose your health information to your benefit provider/insurance company for payment of your treatment and or services rendered in our office. Again, this information may be disclosed electronically or on paper or orally. Under provisions of most benefit providers this information is required for the company to determine benefits and provide payment.

We may use or disclose your health information for our normal healthcare operations. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

We may use your information to contact you. For example, we may send appointment reminder cards. We may also call and remind you about an upcoming appointment. If you are not home, we may leave this information on your answering machine, cell phone voice mail or with the person who answers the telephone. We will use whatever address or telephone number you prefer, however we must have two points of contact for you. We also use an electronic reminder service. We also may use some basic information for internal marketing purposes only. We also may use information for instructional purposes. We do not provide any information to outside marketers or fund raising entities.

In an emergency, we may disclose your health information to the family member designated in your initial information. We may also disclose your health information to emergency treating personnel such as EMT or ER Physicians. We will request updated information on an annual basis. This information may be updated at any time.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we do not use or disclose your health information as described above. We reserve the right to determine if we are able to fulfill your request. Your request may also result in you being fully responsible for all services rendered in our office.

You have the right to see and receive a copy of your health information, with a few exceptions. All requests must be in writing. You may also request a copy for your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information, or if you wish to include a statement in your file, this must be given to us in writing. We may or may not make the changes you request, but will include your statement in your electronic chart. If we agree to an amendment or change, a chart entry will be made noting the amendment or change, our software prohibits deletion of entries and we will not remove or alter earlier documents, but will add new information.

You have the right to a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. At your request in writing, all of your information will be used strictly by our staff and no information will be shared in any manner, however, we will only be able to accept a cash/credit card payment and no insurance benefits will apply.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer D. Michael Connor 12301 Lake Underhill Road. Suite 107 Orlando, FL 32828 407-277-3300

HIPAA Privacy Authorization Form

Authorization for Use of Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

_______**I.** I authorize Dr. Michael H Connor and staff to perform all procedures that are discussed and mutually agreed to in the course of treatment upon myself/the patient. I authorize Michael H Connor and staff to transfer my records to another healthcare provider in the event of a referral for treatment. This authorization in no way obligates me to continue a doctor/patient relationship with any healthcare provider except by and of my own choosing.

_______**II.** I authorize Dr. Michael H Connor to release to hospital or health care service plans, insurance companies, self-insured, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me that is needed to review, investigate or evaluate any claim for benefits. If my coverage is under a group master agreement held by my employer, an association, trust fund, union, or similar entity, their authorization also permits disclosure to them for purposes of utilization review or financial audit.

______**III.** I authorize Dr. Michael H Connor to submit claims for payment for services to my dental insurance company/companies, on my behalf and in my name and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. If the benefits are paid in full at the time of service, benefits will be assigned to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

_____**IV.** I have read a copy of this office's Notice of Privacy Practices. I know that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing, at any time.

______**V. I authorize this office to make routine calls to confirm my appointment and understand a message may be left with a responsible person or an answering machine. I further agree that Dr. Michael H Connor and/or staff members may communicate with me in email and text messages when necessary. This includes but not limited to: text/email to confirm appointments, questions regarding potential treatment, questions following active treatment.**

_____**VI. PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION**: (this includes spouse, children, parents, and any care takers who can have access to this patient's records):
Name: __________________________ Relationship: _________________________
Name: __________________________ Relationship: _________________________

____ ____________________________
Signature of Patient or Personal Representative Date
____ ____________________________
Print Name of Patient or Personal Representative