Notice of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Health Care Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Oregon. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone numbers), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voice mail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Bluefish Dental's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my child(ren)'s protected health information that might occur in his/her treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and Bluefish Dental's duties with respect to my child(ren)'s protected health information. The Notice of Privacy Practices is posted in the facility.

Bluefish Dental 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 child(ren)'s 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 child(ren)'s protected health care information to the persons indicated below:

My child(ren)'s other parent | step-parent | sibling YES NO
If yes, name(s) _____

Grandparent or other child care provider YES NO
If yes, name(s) _____

My child(ren)'s picture may be posted in Bluefish Dental offices YES NO

_____ _____
Name of child(ren) Signature of personal representative

_____ _____
Date Relationship of personal representative

Office Use Only Below Line

Record of Acknowledgement Not Obtained

Provided prior to treatment? YES NO
Date provided_____

Reason for denial:
- ❑ Needed more time to review notice of privacy practices.
- ❑ Wanted to consult with another person, before signing.
- ❑ Unable to sign.
- ❑ Other (explain)_____