DAVID F. RANDOLPH, DMD

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used, disclosed and obtained by you. Please review it carefully, your privacy is important to us.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. The law also requires that we provide this information to you, the patient. This notice takes effect April 14, 2003. We reserve the right to change, any or all, aspects of our privacy practices, at any time. You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

Our practice uses and discloses health information about you for payment, treatment, referrals, and other health care reasons.
Treatment: We will use and disclose your health information for treatment in our office, a referral to a dental specialist, physician or other health care provider providing treatment to you. Payment: We will use and disclose your health information to obtain payment for services rendered. This could be to an insurance company, or another health care provider.
To Your Family and Friends: We may disclose your health information to a family member or friend in an effort to aid in your health care or to obtain payment for services rendered. We will, however, give you the opportunity to object to our use or disclosure. If you are not present, incapacitated, or an emergency situation, we will use our professional judgment of whether the disclosure would be in your best interest We will use our professional judgment to use or disclose information when notifying a person involved in your care, about your location and general condition.
Confirming Appointments: We may use or disclose your health information when we confirm an upcoming appointment This will be done by voice mail, postcard, letter or message left with an individual, other than you, at your home or place of employment
Public Awareness: We may use or disclose your health information for any of the following reasons, as deemed necessary:

- required by law
- public health/disease reporting/child abuse reporting/employers regarding work related illness or injury
- adult abuse, neglect, or domestic violence
- court and administrative orders
- subpoenas concerning crime victims, suspicious deaths, purpose of locating a suspect or other person
- coroners, medical examiners, funeral directors organ donor organizations to avert a serious threat or safety certain research activities
- military or federal officials for lawful intelligence, counterintelligence and national security activities
- correctional institutions regarding inmates
- state worker's compensation laws

Access: You may look at or get copies of your health information at any time, with some exceptions. If you request copies, you may be charged a small fee to cover copying costs and postage. We ask that you make your request in writing.
Amendment: You may request that we amend your health information. This request must be in writing and explain why we should amend this information. Your request may be denied under certain circumstances.

QUESTIONS AND COMPLAINTS

If you believe we have violated your privacy rights, made a decision about access to your health information incorrectly, failed to respond to a request by you, or did not communicate with you 1 alternative means as requested please let ns know. You may also send a written complaint to the **Department of Health and** Human Services. We respect the privacy of your health information and will not in any way retaliate if you choose to file a complaint with the U.S. Department of Health Human Services or us.

David F. Randolph, DMD, PA
1779 SW Barnett Way Suite 101
Lake City, Florida 32025
(386) 755-4033
(386) 755-2581 Fax

DAVID F. RANDOLPH, DMD

ACKNOWLEDGEMENT OF RECEIPT OF

PRIVACY PRACTICES NOTICE

Patient Name: _____ SS#: _____

Address: _____ Phone: _____

_____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from the practice of Dr. David Randolph.

Signature: _____ Date: _____

If someone other than the patient signs, please complete the following

Personal Representative's Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

Good Faith Effort to Obtain Acknowledgement of Receipt

Describe effort to obtain signature:

_____

_____

Describe why the individual would not sign this form:

_____

_____

Signature: _____ Date: _____

Print Name: _____ Title: _____