ROSS & FREDRICKSON, D.D.S.

ABRIDGED NOTICE OF PRIVACY PRACTICES

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US. PLEASE REVIEW AND SIGN BELOW

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We have posted the full-length Notice of Privacy Practices, our legal duties, and your rights concerning your health information on the wall by the reception desk for your review and will also provide a personal copy for you at your request. *The following is an abbreviated form of our notice*. Please do not hesitate to ask any questions concerning this information or to request the unabridged version of this Notice. By signing this form, you are acknowledging you have reviewed our Notice of Privacy Practices (both abridged and unabridged).

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment and payment. For example:

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

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

Your Authorization: In addition to our use of your health information for treatment and payment, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in our unabridged Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of our unabridged Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read and received a copy of this office's NOTICE OF PRIVACY PRACTICES.

Please print patient(s) name(s) _____

Signature of patient/guardian _____ DATE _____

For office use only: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: ___ Individual refused to sign. ___ Communication barriers prohibited obtaining the acknowledgement. ___An emergency situation prevented us from obtaining the acknowledgement. ___ Other (please specify)