



**James D. Rostvold D.D.S.**

**Privacy Notice**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED PLEASE REVIEW IT CAREFULLY.

Your protected information, such as name, birthdate, phone/fax number, email address, home address, social security number/insurance ID and demographic data may be used or disclosed by us in one or more of the following ways:

- To other health care providers, an oral surgeon, endodontic specialist , orthodontist and/or other providers in the event of a case referral of your dental treatment needs;
- To third party payers (insurance companies, employers with direct reimbursement, administrators of flexible spending account, etc.) or spouses in order to determine benefits and obtain payment of your account;
- To certifying, licensing and accreditation bodies (the American Dental Association, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To your immediate family involved in your treatment; and any other health care professional involved in your treatment;
- We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you, (including treatment we carry out, payment activities and healthcare operations.)

Any other uses or disclosures of your protected health information will be made only after obtaining you written authorization, which you have the right to revoke. You may also request restrictions on the use and disclosure of you protected health information and request confidential communication of your protected health information.

**Privacy Consent**

This form is optional under the patient privacy regulations recently issued by the U.S. Dept of Health and Human Services. Prior to commencing your dental treatment, review the Privacy Notice, sign and date this Privacy Consent form, and return this form to the receptionist.

Your protected health information (such as name, birthdate, phone/fax, email address, home address, social security number, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (performance reviews, certification, accreditation and licensure). You have the right to request restrictions on the use of your protected health information.

I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Relationship to Patient (if minor)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

***Please notify receptionist of any changes to insurance, address or phone number.***

***If you have any questions about the information in this Privacy Notice, please ask the receptionist.***