# STATEMENT OF PRIVACY

Nicholas C. Tennison, DDS
901 S Unions, Suite B4008
Tacoma,WA 98405

(253)272-3295

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 concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you pf any changes that might affect your rights.

## PROTECTING YOUR PERSONAL HEALTHCARE 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 Washington. This includes these issues to relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone – even family members- without your consent.

## COLLECTING PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Numbers, 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 voicemail messages, answering machines, email, 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 that stated above. 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.

**Nicholas C. Tennison, DDS**

# NICK TENNISON, DDS

GENERAL DENTISTRY
1901 SOUTH UNION, SUITE B4008 TACOMA, WA 98405
(253)272-3295

## ACKNOWLELEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received and read a copy of the Statement of Privacy Policies for the office of Nick Tennison, DDS. The statement of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in performance of office health care operations. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information This Statement of Privacy Practices is also posted in this facility.

Nick Tennison, DDS reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised copy that one be mailed to me.

### ADDITIONAL DISLOSURE AUTHORITY

In addition the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family ( ) YES ( ) NO

OTHER (please specify) ( ) YES ( ) NO

Name of Patient (print) Date Signature of Patient