HIPAA Notice of Privacy Practices

Last Updated: June 2013

Dr. Michael Wynn, DDS Notice of Privacy Practices

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

I. Dental Practice Covered by this Notice

This Notice describes the privacy practices of Dr. Michael Wynn ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Official

If you have any questions or would like further information about this Notice, you can contact Dr. Michael Wynn's Privacy Official at:

Dr. Michael Wynn
4608 S. Harvard, Suite A
Tulsa, Oklahoma 74135
918-742-7351
918-742-7352
Mikewynndds@gmail.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to:

- Maintain the privacy of your protected health information;
- Give you this Notice of our legal duties and privacy practices with respect to that information; and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on April 1, 2016.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

A. Common Uses and Disclosures

1. Treatment. We may use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

2. Payment. We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

3. Health Care Operations. We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

4. Appointment Reminders. We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, phone call, voice message, text or email.

5. Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose your health information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

6. Disclosure to Family Members and Friends. We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

7. Disclosure to Business Associates. We may disclose your protected health information to our third-party service providers (called, "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

B. Less Common Uses and Disclosures

1. Disclosures Required by Law. We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.

2. Public Health Activities. We may disclose patient health information for public health activities and purposes, which include: preventing or controlling disease, injury or disability; reporting births or deaths; reporting child abuse or neglect; reporting adverse reactions to medications or foods; reporting product defects; enabling product recalls; and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

3. Victims of Abuse, Neglect or Domestic Violence. We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect or domestic violence.

4. Health Oversight Activities. We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.

5. Lawsuits and Legal Actions. We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.

6. Law Enforcement Purposes. We may disclose your health information to a law enforcement official for a law enforcement purposes, such as to identify or locate a suspect, material witness or missing person or to alert law enforcement of a crime.

7. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to a coroner, medical examiner or funeral director to allow them to carry out their duties.

8. Organ, Eye and Tissue Donation. We may use or disclose your health information to organ procurement organizations or others that obtain, bank or transplant cadaveric organs, eyes or tissue for donation and transplant.

9. Research Purposes. We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

10. Serious Threat to Health or Safety. We may use or disclose your health information if we believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.

11. Specialized Government Functions. We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.

12. Workers' Compensation. We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illness.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

A. Right to Access and Review

You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format and to direct us to send it to the person or entity you designate in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.

B. Right to Amend

If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.

C. Right to Restrict Use and Disclosure

You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care or the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception: If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.

D. Right to Confidential Communications, Alternative Means and Locations

You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

E. Right to an Accounting of Disclosures

You have a right to receive an accounting of disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period will be without charge to you. We may charge a reasonable fee to cover the cost for each subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

F. Right to a Paper Copy of this Notice

You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

G. Right to Receive Notification of a Security Breach

We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information.

The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

VIII. Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

IX. Our Right to Change Our Privacy Practices and This Notice

We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request. The effective date of this Notice is April 1, 2016.

X. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Official listed on the first page of this Notice.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Last Updated: June 2013

Dr. Michael Wynn
4608 S. Harvard Ave, Suite A
Tulsa, Oklahoma 74135

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Dr. Michael Wynn's *HIPAA Notice of Privacy Practices*.

I understand that Dr. Michael Wynn's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Dr. Michael Wynn's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Dr. Michael Wynn's *HIPAA Notice of Privacy Practices*, I may contact Dr. Michael Wynn at 918-742-7351.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Dr. Michael Wynn will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Dr. Michael Wynn's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Dr. Michael Wynn, noted above, for assistance.

_____	_____
Patient Signature	Date
_____	_____
Signature of Personal Representative	Print Name of Personal Representative
	_____
	Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Dr. Michael Wynn made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Dr. Michael Wynn was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

Authorization for the Release of Protected Health Information

Last Updated: June 2013

Dr. Michael Wynn
4608 S. Harvard Ave, Suite A
Tulsa, Oklahoma 74135

PLEASE PRINT CLEARLY

Patient Name _____ Today's Date _____

Address _____ Date of Birth _____

City, State ZIP _____ Email _____

Phone _____ Fax _____

Patient Authorization

I, _____, hereby authorize Dr. Michael Wynn to release, use and/or disclose my protected health information as directed below.

Health Information

This Authorization pertains to the following types of protected health information about me:

- ☐ All dental records received or created by Dr. Michael Wynn
- ☐ Dental report(s) (please specify) _____
- ☐ Dental image(s) (please specify) _____
- ☐ All dental records relating to (specify injury or condition) _____
- ☐ Other (please describe) _____

Release Information

Please release my health information to:

Organization _____ Phone _____

Contact _____ Email _____

Address _____ Fax _____

City, State ZIP _____ Handling Notes _____

I understand that, per my voluntary request, this Authorization permits, Dr. Michael Wynn, to release, use or disclose my protected health information for purposes other than payment, treatment, or healthcare operations as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its corresponding regulations. I further understand that I may revoke this Authorization at any time by providing written notification to Dr. Michael Wynn Revocation of this Authorization will be effective on the date notice is received and processed by Dr. Michael Wynn except to the extent that action has already been taken in reliance upon this Authorization.

Authorization Expiration

This Authorization will expire one (1) year from the date that I sign it, unless I indicate an alternative expiration date below:

Enter Alternative Expiration Date: _____ , 20_____

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Dr. Michael Wynn
4608 S. Harvard Ave, Suite A
Tulsa, Oklahoma 74135

Know Your Rights

Your decision to sign this Authorization is voluntary. Dr. Michael Wynn will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting Dr. Michael Wynn to release, use or disclose my protected health information.

Signature	Date
Print Name	Witness (Optional)

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature	Date
Print Name	Relationship to Patient

☐ Parent ☐ Guardian ☐ Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID

WYNN DENTISTRY | **Michael J. Wynn D.D.S.**

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient Information

Patient's name _____ Preferred name _____ Birth date _____

If a minor, guardian's name _____ Email address _____

Home phone _____ Work phone _____ Cell phone _____

Mailing Address _____ City _____ State _____ Zip _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____ ○ Unmarried

Whom may we thank for referring you to our office? _____ ○ Online

Billing, Credit, & Insurance Information: ○ Not covered by dental insurance

Social security number _____ Dental insurance co. _____ Group no. _____

Covered by spouse's insurance? ○ Yes ○ No

Spouse's dental insurance company _____ Group no. _____

Spouse's birthday _____ Social security number _____

Medical Health History

Do you have or have you had any of the following? (Check any that apply)

- ○ Cancer or tumor
- ○ Heart ailment or angina
- ○ Heart murmur, mitral valve prolapse, heart defect
- ○ Rheumatic fever or rheumatic heart disease
- ○ Artificial joint or valve
- ○ High or low blood pressure
- ○ Pacemaker
- ○ Tuberculosis or other lung problems
- ○ Kidney disease
- ○ Hepatitis or other liver disease
- ○ Alcoholism
- ○ Blood transfusion
- ○ Diabetes
- ○ Neurological condition
- ○ Epilepsy, seizures, or fainting spells
- ○ Emotional condition
- ○ Arthritis
- ○ Herpes or cold sores
- ○ AIDS or HIV positive
- ○ Migraine headaches or frequent headaches
- ○ Anemia or blood disorders
- ○ Abnormal bleeding after extractions, surgery, or trauma
- ○ Hay fever or sinus trouble
- ○ Allergies or hives
- ○ Asthma

Do you smoke or use chewing tobacco? ○ Yes ○ No

Have you been admitted to the hospital or had any surgeries in the past 5 years? Please explain

_____

_____

Please list current medications, prescription or over the counter

_____

_____

_____

Are you taking or have you ever taken Bisphosphinates? (i.e. Fosamax, Boniva)? If yes, when?

Are you allergic to, or have you reacted adversely to any of the following?

○ Latex materials ○ Penicillin or other antibiotics ○ Local anesthetics (Novocain) ○ Codeine or other narcotics

○ Sulfa drugs ○ Barbiturates, sedatives, or sleeping pills ○ Aspirin Other: _____

Women:

○ May be pregnant Expected delivery date: _____

Name of your physician: _____

Do you have any disease, condition, or problem not listed above? _____

When was your last dental visit? _____

Is there anything you dislike about your teeth or smile? _____

Please add any other information you would like us to know about: _____

Emergency Contact Information

Name _____ Phone number _____ Relationship to patient _____

I hereby authorize Dr. Wynn to furnish information to insurance carriers concerning this exam or treatment and I hereby irrevocably assign to the doctor all insurance benefits otherwise payable to me but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of patient (or guardian) _____ Date _____