

NOTICE OF PRIVACY PRACTICES

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

We are required by law and under the HIPPA Privacy Rule to maintain privacy of your health information. In addition, we are required to provide you with our legal duties and privacy practices with respect to information we collect and maintain about you. We must comply with the terms of this notice. We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. IF and when this notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice upon request to our Privacy Official.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Muy E. Sun, DDS, PLLC may use and/or disclose your health information for the following reasons:

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment: We may use and disclose our health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for such purposes as controlling disease, injury or disability.

Abuse or Neglect. We may disclose your PHI to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Security of HHS. We will disclose PHI to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPPA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil right laws.

Lawsuits and Disputes. We may disclose PHI about you in a response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful purposes.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSURES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this letter. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Rights to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care

operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record (s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied and explain your rights.

Right to a Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by email.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Official at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with our Privacy Official or the U.S. Department of the Health and Human Services. We will not retaliate or take action against you for filing a complaint.

US Department of Health and Human Services
Office of the Secretary
200 Independence Ave. SW
Washington DC 20201
Phone: 202-619-6775
Toll free: 1-877-696-6775
<http://www.hhs.gov/contacts>

Muy E. Sun, DDS, PLLC
Privacy Office
907 N. 130th Street
Seattle, WA 98133
Phone: 206-362-6116
Fax: 206-440-8411

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have read the attached copy of the Notice of Privacy Practices for Muy E. Sun, DDS, PLLC. I understand that I have the right to request a copy of this notice at any time.

I also give my consent for Muy E. Sun, DDS, PLLC to release my Protected Health Information for the purposes of treatment, payment and healthcare operations as described in this notice.

ADDITIONAL DISCLOSURE AGREEMENT AUTHORITY

In addition to the allowable disclosures described in the Notice 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

SPOUSE ONLY

YES NO

OTHER (please specify):

YES NO

I, _____, also give Muy E. Sun, DDS, PLLC permission to leave a voicemail regarding my dental care procedure or appointment reminder at:

YES Home Phone _____ Work Phone _____

NO

Printed Name of Patient or Guardian: _____ Date: _____

Signature of Patient or Guardian: _____ Date: _____

Thank you for helping us to serve you better!