MAGNA DENTAL, PC
NOTICE OF PRIVACY PRACTICES-HIPAA

(REVISED 1/24/2023)

DUE TO THE 1996 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT KNOWN AS "HIPAA", WE WILL FOLLOW THE TERMS OF THIS NOTICE AND MAY SHARE YOUR INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND FOR DENTAL/HEALTH CARE OPERATIONS AS DESCRIBED IN THIS NOTICE. THE INFORMATION IN THIS NOTICE WILL BE FOLLOWED BY ALL OF THE EMPLOYEES OF MAGNA DENTAL, PC, AND OTHER ENTITIES WHICH ARE LEGALLY SEPARATE, INDEPENDENT AGENTS, HEALTH/DENTAL CARE PROFESSIONALS, AND ALL BUSINESS ASSOCIATES WITH WHOM WE SHARE YOUR HEALTH AND DENTAL INFORMATION.

OUR PLEDGE

WE UNDERSTAND THAT YOUR INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE FOR THIS DENTAL OFFICE. WE ARE REQUIRED BY LAW TO KEEP YOUR INFORMATION PRIVATE AND GIVE YOU THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO THE MEDICAL, DENTAL, AND FINANCIAL INFORMATION ABOUT YOU AND TO NOTIFY YOU IN THE EVENT OF A BREACH OF YOUR INFORMATION.

CHANGES TO THIS NOTICE

WE RESERVE THE RIGHT TO CHANGE OUR NOTICE OF PRIVACY PRACTICES AT ANY TIME. CHANGES WILL APPLY TO INFORMATION WE ALREADY HOLD, AS WELL AS ANY NEW INFORMATION, AFTER THE CHANGE OCCURS. BEFORE WE MAKE ANY SIGNIFICANT CHANGES, WE WILL CHANGE THIS NOTICE AND POST THE NEW NOTICE IN OUR OFFICE, AS WELL AS PROVIDE A CURRENT COPY TO YOU AT YOUR REQUEST.

HOW WE MAY USE YOUR INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

(THESE ARE EXAMPLES AND NOT A COMPLETE LIST OF EVERY KIND OF USE)

FOR TREATMENT-TO GIVE INFORMATION TO YOUR DOCTORS, NURSES, AND OTHERS INVOLVED IN YOUR HEALTH OR DENTAL CARE. THIS INCLUDES SHARING AND/OR RECEIVING OF PRESCRIPTION INFORMATION WITH A NATIONAL PRESCRIPTION DATABASE UTILIZED IN ELECTRONICALLY PRESCRIBING MEDICATIONS FOR TREATMENT AS WELL AS PHARMACIST. WE ALSO WILL CONTACT YOU FOR APPOINTMENTS, TO DESCRIBE, RECOMMEND OR REFER YOU FOR POSSIBLE TREATMENT OPTIONS, ALTERNATIVES OR OTHER RELATED PRODUCTS OR SERVICES.

FOR PAYMENT-CREATING BILLS AND COLLECTING PAYMENT FOR YOUR CARE.

TO LEGAL REPRESENTATIVES-SUCH AS YOUR PARENTS IF YOU ARE UNDER THE AGE OF 18.

TO PERSONS INVOLVED IN YOUR CARE OR PAYMENT OF CARE-SUCH AS A FAMILY MEMBER OR A FRIEND IDENTIFIED BY YOU IN WRITING.

AS REQUIRED BY LAW-IF WE MUST DISCLOSE INFORMATION TO COMPLY WITH A FEDERAL, STATE, OR LOCAL LAW.

FOR PUBLIC HEALTH PURPOSES-SUCH AS TO REPORT SUSPECTED CHILD NEGLECT OR ABUSE.

FOR OVERSIGHT ACTIVITIES-SUCH AS TO GOVERNMENT OR PRIVATE AGENCIES AS A PART OF AN AUDIT OR INSPECTION BY A GOVERNMENT AGENCY WHICH ISSUES OUR LICENSE.

FOR DENTAL OPERATIONS-SUCH AS ADMINISTRATION, MANAGEMENT, BUSINESS PLANNING, AND OUR OTHER OPERATIONS.

FOR WORKER'S COMPENSATION PURPOSES-TO COMPLY WITH THE ILLINOIS WORKER'S COMPENSATION LAWS OR SIMILAR PROGRAMS THAT PROVIDE BENEFITS FOR WORK-RELATED INJURIES/ILLNESS.

FOR DISASTER RELIEF-SUCH AS TO AN ORGANIZATION HELPING WITH DISASTER RELIEF TO HELP YOUR FAMILY LOCATE YOU.

FOR LAWSUITS AND DISPUTES-SUCH AS IN RESPONSE TO A VALID COURT ORDER OR SUBPOENA.

TO AVERT A SERIOUS THREAT TO YOUR HEALTH OR SAFETY-AS TO PREVENT OR LESSEN A SERIOUS THREAT TO THE HEALTH AND SAFETY OF YOU, THE PUBLIC, ETC.

FOR CORRECTIONAL INSTITUTIONS-TO AN INSTITUTION WHICH YOU ARE AN INMATE IN ORDER TO PROTECT YOU HEALTH AND SAFETY OR THAT OF OTHERS.

FOR MILITARY AND VETERAN ACTIVITIES-TO DISCLOSE INFORMATION ABOUT A MEMBER OR VETERAN OF THE ARMED FORCES TO APPROPRIATE MILITARY AUTHORITIES.

FOR NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES-SUCH AS TO FEDERAL OFFICIALS FOR INTELLIGENCE AND OTHER NATIONAL SECURITY ACTIVITIES AUTHORIZED BY LAW.

FOR PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHER OFFICIALS-INFORMATION TO AUTHORIZED FEDERAL OFFICIALS FOR THE PUPOSE OF PROTECTING THE PRESIDENT, OR OTHER HEADS OF STATE.

FOR DISCLOSURES ABOUT A PERSON WHO HAS DIED OR IS NEAR DEATH-SUCH AS TO FUNERAL DIRECTORS, CORONER, MEDICAL EXAMINERS, ETC. TO IDENTIFY A PERSON.

INTERNET COMMUNICATIONS-THIS OFFICE WILL UPLOAD AND STORE YOUR CONFIDENTIAL INFORMATION TO A SECURED WEB SITE FOR THIS DENTAL OFFICE. THE WEB SITE REQUIRES A USER ID AND PASSWORD FOR OUR EMPLOYEES TO ACCESS AND USE. THIS OFFICE WILL COMPLY WITH ALL THE LAWS APPLICABLE FOR THE GATHERING, USE, TRANSMISSION, PROCESSING, RECEIPT, REPORTING, DISCLOSURE, MAINTENANCE, AND STORAGE OF YOUR INFORMATION, AND USE OUR BEST EFFORTS TO HAVE ALL ENTITIES UNDER OUR DIRECTION OR CONTROL TO COMPLY WITH SUCH LAWS. YOU AGREE THAT THIS OFFICE HAS THE RIGHT TO MONITOR, RETRIEVE, STORE, UPLOAD AND USE YOUR INFORMATION IN CONNECTION WITH THE OPERATION OF SUCH SERVICES, AND IS ACTING ON YOUR BEHALF IN UPLOADING YOUR INFORMATION. YOU UNDERSTAND THAT THIS OFFICE WILL USE COMMERCIALLY REASONABLE EFFORTS TO MAINTAIN THE CONFIDENTIALITY OF ALL YOUR INFORMATION THAT IS UPLOADED TO THE WEBSITE.

YOUR RIGHTS

IF YOU FEEL THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED PLEASE CONTACT OUR OFFICE MANAGER AT 217-525-6980. YOU MAY ALSO FILE A WRITTEN COMPLAINT WITH THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE FOR CIVIL RIGHTS. WE HONOR YOUR RIGHT TO MAKE A COMPLAINT AND WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

****WE MUST OBTAIN YOUR WRITTEN AUTHORIZATION TO GIVE YOUR INFORMATION OUT TO ANY CATEGORY NOT LISTED ABOVE OR NOT AUTHORIZED BY LAW.****

****WE CHARGE $25.00 FOR YOUR RECORDS TO BE COPIED WITH FED EX DELIVERY WITH YOUR SIGNATURE REQUIRED. OR YOU CAN PICK THEM UP IN PERSON. WE WILL NOT MAIL, FAX, ETC. YOUR RECORDS.****

****YOU ARE REQUIRED TO GIVE OUR OFFICE A CORRECT PHONE NUMBER THAT IS SECURE THAT WE MAY LEAVE MESSAGES REGARDING YOUR ACCOUNT, APPOINTMENTS, AND YOUR CARE AT. WE ARE NOT RESPONSIBLE FOR OTHERS READING YOUR EMAILS, PHONES, LISTENING TO YOUR MESSAGES, ETC.****

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(REVISED 1/24/2023)

YOU ACKNOWLEDGE/UNDERSTAND/RECEIVED/READ THE PRIVACY PRACTICE AND PROCEDURES FOR THE OFFICE OF MAGNA DENTAL PC. IT EXPLAINS AND OUTLINES HOW YOUR MEDICAL/DENTAL/FINANCIAL INFORMATION MAY OR MAY NOT BE USED/DISCLOSED*

YOU AUTHORIZE MAGNA DENTAL, PC, ITS DOCTORS AND STAFF TO DISCUSS YOUR MEDICAL HISTORY/TREATMENT TO ENABLE PROPER EFFECTIVE DENTAL CARE WITH YOUR PHYSICIANS/NURSES/INSURANCE COMPANIES/HEALTH CARE GIVER, ETC AS EXPLAINED AND OUTLINED IN THE PRIVACY AND PROCEDURES*

INDIVIDUALS THAT YOU GIVE AUTHORIZATION TO ACCESS YOUR RECORDS OR FILES:

NAME	PHONE
_____	_____
_____	_____
_____	_____
_____	_____

SIGNATURE OF PATIENT: _____ **DATE:**_____

SIGNATURE OF PARENT/GUARDIAN/POA: _____ **DATE:** _____
(PATIENT IS AGE 18 OR YOUNGER)

***YOU AUTHORIZE MAGNA DENTAL, PC TO FAX DENTAL EXAM DOCUMENTS TO THE SCHOOL DISTRICT OF YOUR CHOICE:** _____
***OR MILITARY BRANCH OF SERVICE:** _____
***OTHER**: _____

PATIENT UNABLE TO SIGN:___

PATIENT REFUSES/DECLINES TO SIGN:___