Dental Practice of Vang (Peter) Ly, DDS
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Notice of Privacy Practices

Consent for Use and Disclosure of Health Information

YOUR HEALTH INFORMATION

We are required by law to give you this notice, which describes the information about privacy practices followed by our employees, staff, and other office personnel.

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written consent to use and disclose health information for the following purposes: Treatment, Payment, Healthcare Operations, Appointment Reminders, Treatment Alternatives, Health-related Products, and Services.

Special situations in which we may disclose health information about you without your permission for the following purposes: To avert a serious threat to health or safety, required by law, research, organ and tissue donation, military, veterans, national security and intelligence, worker's compensation, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, medical examiners, and funeral directors.

Information not personally identifiable to disclose health information about you in a way that does not personally identify you or reveal who you are includes: Family and Friends.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you. Right to inspect and copy, right to amend, right to accounting of disclosures, right to request confidential communications, right to a paper copy of this notice, right to request restrictions. We are not required to agree to your request if we do not agree; we will comply with your request unless the information is needed to provide you emergency treatment.

SIGNATURE

I, ________________________________, have had the full opportunity to read and consider the content of your Notice of Privacy Practices. I certify that I understand the above consent to my health information and anything I did not understand has been explained to me. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care options.

______________________________________ ____________________

Signature Date

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.