Drs. Delany & Moiseiwitsch, P.C.

Diplomates, American Board of Endodontics

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Notice of Privacy Practices

This "Notice of Privacy Practices" contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information.

Uses and disclosures of health information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

In the following circumstances, we may disclose your health information WITHOUT your written authorization:

- For purposes of public health and safety.
- To government agencies for purposes of their audits, investigations and other oversight activities.
- To government authorities to prevent child abuse or domestic violence.
- To the FDA to report product defects or incidents.
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law.
- For certain limited research purposes.

Uses and disclosures based on your authorization:

- To family members who are involved in your health care.

PLEASE COMPLETE THE ATTACHED FORM!

Patient rights:

- As our patient, you have the following rights:
- To have access to and/or a copy of your health information.
- To receive an accounting of certain disclosures we have made of your health information.
- To request that we communicate with you in confidence.
- To receive notice of our privacy practices.

HIPAA Privacy Acknowledgement

I, _____ have received a copy of Dr. Gael M. Delany and
PLEASE TYPE NAME
Dr. Julian R.D. Moiseiwitsch's "Notice of Privacy Practices". By signing below I authorize my digital health records to forwarded to my Referring Dentist or any other health care provider who is providing care for me.

_____ _____
Signature of Patient Date

PLEASE COMPLETE FORM BELOW

Dr. Gael M. Delany and Dr. Julian Moiseiwitsch's office has permission to release information regarding my dental treatment to the following:
Information pertaining your treatment or account at our office will not be released to persons not authorized by you!

- o My Spouse
  _____
  Print Name Contact Number
- o My Children
  _____
  Print Name Contact Number
  _____
  Print Name Contact Number
- o Parent(s)
  _____
  Print Name Contact Number
  _____
  Print Name Contact Number
- o Other
  _____
  Print Name Contact Number

Optional Disclosures:
Telephone messages may be left on my (PLEASE CHECK):

- o Home Phone _____
- o Cell Phone _____
- o Work Phone _____