



Patient's Name : Last First:
DOB:

NOTICE OF PRIVACY PRACTICES:

Our Commitment to Protecting Your Privacy and Earning Your Trust

Earning and maintaining your trust and safeguarding your privacy is the cornerstone of our patient relationship with you. The protection of your privacy is a key part of maintaining your trust here at Hakuna Matata Pediatric Dentistry. This is a fundamental operating principle for us. The Patient Privacy Notice let you know the information we collect about you, and how we safeguard and use this information to serve you.

Information We Collect about You (Protected Health Information:PHI)

We collect non-public information about you as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the state of Florida from the following sources:

- Information you provide directly to us upon registration, including financial contracts.
- Information we obtain from others to verify information provided by you, such as your insurance policy information, and healthy history.

We only collect and use patient information that is necessary to render our procedures, provide superior services and make you aware of services that we believe will be a benefit and value to you.

Information We Disclose to Others

We do not disclose any non-public, personal information about our patients (active or inactive), to non-affiliated third parties, without written consent from the patient. We are concerned about you and your privacy, and carefully limit and control the patient information we share with others. We will not use your information for marketing purpose without your prior written authorization. We may use your personal health information to communicate reminders for appointments including voicemail messages, answering machines and postcards. We do not disclose any information about our patients (active or inactive) to anyone except as outlined in this notice, or as permitted by law.

Our Security Procedures and Our Pledge to You

We are committed to protecting the security of our patient information. We maintain strict internal policies regarding confidentiality of patient information. We limit access to this information to only those employees who require it to perform their jobs safely and accurately. We maintain physical, electronic and procedural safeguards that comply with federal and state guidelines to safeguard patient information. Our employees are bound by our policies to access patient information only for legitimate clinical and/or business purposes and to keep such information confidential at all times. We pledge to do all we can to protect your privacy. Any breach in the protection of your Personal Health Information, including unauthorized access, acquisition, use or disclosure will be fully investigated, addressed and mitigated as established by the HIPAA Privacy Rule.

Your Right as a Patient

You have the right as a patient to request copies of your healthcare information; to request copies in various formats; and to request a list of instances in which, we or our business associates have disclosed your information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by the law of the State of Florida. You have a right to and will be provided all information related to a breach involving your personal PHI. If you have any questions about our Privacy Policy, or about how your information is maintained, safeguarded or used, please contact our Privacy Officer at 239-232-4000.

If you believe your privacy rights have been violated, we urge you to notify us immediately at 239-232-4000. You may also notify the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Aline Morin at mydentist@hakunakidsdentistry.com.

All complaints must be made in writing. You will not be penalized for filing a complaint.

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed that Hakuna Matata Pediatric Dentistry retains a more complete description of the use and disclosures of my health information (available in office in print form) and I might requested. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Hakuna Matata Pediatric Dentistry retains the right to change its Notice of Privacy Practices from time to time and that I may contact Hakuna Matata Pediatric Dentistry at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Hakuna Matata Pediatric Dentistry restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Hakuna Matata Pediatric Dentistry is not required to agree to my requested restrictions, but if it does agree, then it is bound by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Hakuna Matata Pediatric Dentistry has taken action relying on this consent.

Parent or Legal Guardian Signature: _____ Date: _____