LYNNWOOD
PERIODONTICS & IMPLANTS
BRIAN BRANCHEAU, DDS, MSD

STATEMENT OF PRIVACY POLICIES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you in strict accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the state of Washington. This includes issues relating to your treatment, payment, and other dental office operations. Your personal health information will never be revealed to anyone without your written consent. You may give us written permission to allow disclosure of your information to anyone you choose for any reason.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to protect the confidentiality of your records. Our privacy policy and practices apply to all past, present and future patients of the practice, and your health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our high standard of dental care, process payment and insurance information, perform regular dental practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties when deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

We are required to provide information to governmental officials and law enforcement in specific cases. Your information will not be used for marketing purposes without obtaining your written consent. We may disclose your health information to communicate reminders about your appointments including voicemail messages, text messages, emails, and postcards.

Patient Rights

You have a right to request copies of your healthcare information in various formats, and to request a list of circumstances in which we have disclosed your protected information other than for uses stated above. All requests must be in writing. We may charge a reasonable amount allowed by law for copies of your records. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services. Please let us know if you have any questions concerning your right to privacy and protection of your personal health information. Thank you for choosing our office as your dental health care provider.

Lynnwood Periodontics and Implants
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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the statement of the privacy policies for Lynnwood Periodontics and Implants. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of standard health care office operations. The Statement of Privacy Practices also describes my rights, responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Lynnwood Periodontics and Implants reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become enacted. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise provided to me.

ADDITIONAL DISCLOSURE AUTHORITY:

In addition to the allowable disclosures described in the Statement 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: _____

_____ _____
Name of Patient/Authorized Representative Signature of Patient/Authorized Representative

_____ _____
Date Title of Representative

OFFICE USE ONLY BELOW THIS LINE

Record Of Acknowledgement not Obtained
Provided Prior to Treatment □ Yes □ No
Date Provided: _____

Reasons for Denial: □ Needed more time to review statement of privacy practices
□ Wanted to consult with another person before signing
□ Unable to sign
□ Reason not given
□ Other, please explain _____

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