NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN ACCESS YOUR INFORMATION. PLEASE READ IT CAREFULLY.

ABOUT THIS NOTICE

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" includes demographic information, that may identify you and relates to your past, present, or future physical or mental health condition and related health care services including dental care.

This Notice takes effect 10-26-2021. We reserve the right make updates. Updated Notices will be available in our office as well as on our website.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. To obtain a copy please contact the office or visit our website at ***www.wintergardensmiles.com.***

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of our practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to another provider to whom you have been referred so they have the necessary information to treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your services. For example, filing for insurance benefits as applicable for our practice.

Healthcare Operations: We may use or disclose your protected health information as needed, in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of interns, licensing, billing services, and other business activities. We may also use a sign-in sheet, call you by name in the waiting room, send appointment reminders via phone, email, or text, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your PHI for fundraising activities, we will provide you the choice to opt out. You may also choose to opt back in.

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We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. We will make disclosures to you upon your request.

Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. We may disclose your PHI to a personal representative, such as a spouse, relative, or caretaker involved in your care related to their involvement in your treatment or payment of services providing you identify these individual(s) and authorize the release of information. If a young adult age of legal age requests that their information not be released to a parent or guardian, we must comply with this request.

Without your authorization, we are expressly prohibited from using or disclosing your PHI for marketing, fundraising, or research purposes. We may not sell your PHI without your authorization. You may revoke these authorizations, at any time, in writing, except to the extent that we have already taken an action based upon your prior authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your PHI whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, PHI restricted by law, information that is related to research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your requested restriction except if you request that we not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

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You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – This request must be made in writing and we have 30-days to reply. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. We may deny amending your PHI if we did not create the information or if the treating provider who created the information is no longer available to make the amendment.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting (listing) of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We would notify you if your unsecured PHI held by our practice or a business associate has been breached. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users.

You have the right to obtain a paper copy of this Notice from us even if you have agreed to receive the Notice electronically. We will also make available copies of our new Notice if you wish to obtain one.

We reserve the right to change the terms of this Notice. The new Notice will be available upon request, posted in our office, and on our website.

COMPLAINTS

You may file a complaint with us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

If you have any questions or wish to file a complaint, please contact us at:

Winter Garden Pediatric Smiles
Winter Garden Smiles
407-614-5955

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 F HHH Building
Washington, DC 20201
www.hhs.gov/ocr

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