THOMAS J. HERRICK, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization

We may use and disclose PHI without your written authorization for certain purposes except as described below. The examples provided in each category are not meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose, treat, and provide dental services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

2. Payment: Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. Under Washington state law, releases of PHI to health plans require an authorization provided by you to us or to your health plan.

3. Health Care Operations: We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: We may use and disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI, disclosures to judicial and law enforcement officials in response to a court order lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law.

5. Your Other Health Care Providers: We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services

rendered to you, or conduct certain health care operations, such as quality assessment and improvement activities.

B. Uses and Disclosures That May Be Made Without Your Authorization, but for Which You Have an Opportunity to Object.

1. Appointment Reminders: Unless you object, we may use or disclose PHI in order to provide you with appointment reminders such as voicemail messages, postcards, or letters.

2. Family and Other Persons Involved in Your Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your present representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

C. Uses and Disclosures Requiring Your Written Authorization

1. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may receive any such authorization at any time.

2. Marketing Communications: We must obtain your written authorization ("Your Marketing Authorization") prior to using PHI to send you and marketing materials. (We may, however, provide you with marketing materials in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

3. Uses and Disclosures of Your Highly Confidential Information: In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or (9) is about sexual assault. In order for us to disclose Your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy: You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications: You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions: You have the right to request a restriction on PHI we use or disclose for treatment, payment, or health care operations. You must request such restriction in writing, addressed to the HIPAA Officer at Dr. Herrick's office. We are not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures: Upon written request you may obtain an accounting of certain disclosures of PHI made by me after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request from the HIPAA Officer at Dr. Herrick's office.

G. Questions and Complaints: If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may file a written complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date: This Notice is effective on April 14, 2003

B. Changes to this Notice: We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office. You may also obtain any revised notice by contacting Dr. Herrick's office at 456-3166.

THOMAS J. HERRICK, D.D.S.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I (please print)_____, acknowledge that I received a copy of the Notice of Privacy Practices for Thomas J. Herrick, D.D.S.

_____ _____
Signature of patient Date

If this acknowledgement is signed by a personal representative or guardian on ***behalf of the patient***, please complete the following:

Patient's name (s):_____

Personal Representative/Guardian's Name: _____(please print)

Relationship to patient(s): _____ _____
Signature of guardian

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)_____

_____ _____
Employee Name Date

This form will be retained in your medical record.