

Maple Leaf Dental

7750 15th Ave N.E., Suite A, Seattle, WA 98115 • (206) 402-3402 • Fax: (206) 402-3460

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____, hereby authorize:

_____ (dentist/clinic name)

_____ (address)

_____ (city, state, zip)

_____ (phone/fax number)

to release information and x-rays contained in my dental records to:

Maple Leaf Dental
7750 15th Avenue NE, Suite A
Seattle, Washington 98115
office@mapleleafdental.com

Information requested: Full mouth/panoramic x-rays if less than 5 years old, most recent bitewings, periodontal charting, date and type of the last dental cleaning and any other information or reports that would be useful for future treatment.

Maple Leaf Dental is hereby released from all legal responsibility or liability for the release of the above mentioned disclosure of information.

I understand that I have the right to withdraw this authorization at any time, and that such revocation must be in writing. Further, I understand that this authorization, without prior revocation will expire 90 days from the date of signature.

Signature of
Patient _____

Printed Name of
Patient _____

Date _____

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Notice of Privacy Practices Acknowledgement

We keep a record of the private health information and health services we provide for you. We use your information for your dental care. You may request to see, receive and/or make corrections to that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Your information can and will be used to conduct, plan and direct your treatment and follow-up among multiple healthcare providers who may be involved in treatment directly or indirectly and to obtain payment from third-party payers. If we use your information for any other purpose, we must inform you.

All requests regarding your personal health information/record, including access to a copy, lodging a complaint, request for accounting of disclosure, requests to amend your patient record or more information regarding Maple Leaf Dental's Privacy Practices, contact the Privacy Officer Dr. Susan S. Miller at 206-402-3402.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our **Notice of Privacy Practices**.

My signature confirms I acknowledge access to the **Notice of Privacy Practices**, and have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Additional Disclosure of Authority

In addition to allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorized disclosure of my protected health care information to the following ; (initial all that apply)

_____ Cell phone _____ Personal email
_____ Land line _____ OK to leave a message with someone who may answer the phone
_____ Work phone _____ Work email
_____ Text Carrier: _____
_____ Family member only
_____ other (please specify) _____

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent Family members also covered by this acknowledgement.

MLD staff: If not signed, please document why.

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Name: _____ Preferred Name: _____
(Last) (first) (middle initial)

Preferred pronoun: _____ Single: ___ Married: ___ Partner's Name: _____

Date of Birth: _____ Soc. Sec.#: _____ Parent: _____ (if minor)

Address: _____ City: _____ State: _____ Zip: _____

Cell: (____) _____ Work: (____) _____ LandLine: (____) _____

Email: _____ Referred by: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____

Employer & Group #: _____

Name of Subscriber (other than self): _____

DOB: _____ SS#: _____ Ins. ID# _____

Secondary Dental Insurance: _____

Employer & Group #: _____

Name of Subscriber (other than self): _____

DOB: _____ SS#: _____ Ins. ID# _____

Medical Information

Physician's Name: _____

Allergies to medications? _____ Yes _____ No

If yes, please list: _____

Other Allergies: _____

Are you currently taking any medications? _____ Yes _____ No

List Current Medications/reason for taking: _____

Date of last physical exam? _____

Other Medical Conditions: _____

MEDICAL HISTORY

____ Yes ____ No Heart Disease

____ Yes ____ No Heart Defect

____ Yes ____ No Heart Murmur

____ Yes ____ No Heart Surgery

____ Yes ____ No Pacemaker

____ Yes ____ No Stroke

____ Yes ____ No High Blood Pressure

____ Yes ____ No Artificial Joints

____ Yes ____ No PreMed for Dental Care

____ Yes ____ No Diabetes

____ Yes ____ No Cancer/Tumor

____ Yes ____ No Radiation

____ Yes ____ No Chemo

____ Yes ____ No Epilepsy

____ Yes ____ No Anemia

____ Yes ____ No Prolonged bleeding

____ Yes ____ No Tuberculosis

____ Yes ____ No Lung Disease

____ Yes ____ No Asthma

____ Yes ____ No Inhaler use

____ Yes ____ No Sinus Infections

____ Yes ____ No Acid reflux

____ Yes ____ No Liver Disease

____ Yes ____ No Jaundice

____ Yes ____ No Arthritis

____ Yes ____ No Glaucoma

____ Yes ____ No Venereal Disease/STD

____ Yes ____ No HIV+

____ Yes ____ No Smoker/Vaper

____ Yes ____ No Marijuana use

____ Yes ____ No Illicit drug use

____ Yes ____ No Oral Contraceptives

____ Yes ____ No Pregnant--DueDate: _____

____ Yes ____ No Surgery:

I am financially responsible for my own account. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. If insurance coverage exists, I authorize payment to go directly to my dentist.

Signature _____

Date _____

Maple Leaf Dental

NOTICE OF PRIVACY PRACTICES

Effective March 1, 2020

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

A federal law commonly known as HIPAA (Health Insurance Portability and Accountability Act of 1996) and certain state laws require that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As a part of this process, we are required to provide you with the following Notice of Privacy Practices and to request that you sign a written acknowledgement that you received a copy of the Notice. The Notice describes how medical information about you may be used or disclosed and how you can get access to this information.

Except as otherwise permitted or required by law, uses and disclosures not described in this notice will be made only with your authorization.

This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

Please take a moment to review our Notice of Privacy Practices. We also request that you sign and return the Acknowledgement of Receipt of Notice of Privacy Practices documenting that you received a copy of our Notice. If you have questions about this Notice, or if you need more information, please contact our Privacy Officer at 206-402-3402.

You have certain rights-and we have certain legal obligations- regarding the privacy of your Protected Health Information ("PHI"). This Notice explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice, which may be amended from time to time.

What is Protected Health Information? PHI is information that individually identifies you and that we create or get from you or from another healthcare provider, health plan, your employer, or a health care clearinghouse, and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you or (3) the past, present or future payment for your health care.

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

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Uses and Disclosures Permitted without Your Written Authorization

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

Treatment: We may use and disclose PHI in order to provide medical treatment or services to you, and to manage and coordinate your medical care. For example, we may disclose your PHI to a physician or other health care provider (e.g. a specialist or a laboratory) to who you have been referred, or who are involved in your treatment, to ensure that the provider has the necessary information to diagnose or treat you or provide you with a service.

Payment: We may use and disclose PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan or a third party. For example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services we have recommended for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and prior authorization of services. We may also give information to someone other than an insurance company who pays for your care.

Health Care Operations: We may use and disclose PHI about you for operational purposes. These uses and disclosures are necessary to run Maple Leaf Dental effectively and efficiently, and to make sure that all of our patients receive quality care. These uses and disclosures may include quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities, and for accounting, legal, risk management, insurance services, and audit functions including fraud and abuse detection and compliance programs. We may also use or disclose PHI if your health plan requests it for quality review.

Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. We are required to disclose your health information to you at your request. We are also required to disclose PHI to the Secretary of the US Department of Health and Human Services when required to investigate our compliance with the

HIPAA Privacy Rule. We are permitted to 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. Other disclosures permitted or required by law include disclosures to correctional institutions, law enforcement, coroners, medical examiners, funeral directors, disclosures for health and safety oversight activities, disclosure for workers compensation claims, disclosures for military or national security functions, and disclosures in response to a court order or other lawful process.

Your Other Health Care Providers: We may 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 a quality assessment and improvement activities.

Appointment Reminders and Treatment Alternatives: We may use and disclose PHI to contact you to remind you that you have an appointment for care.

Research: We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit a researcher to look at PHI to help them prepare for research. We may use and disclose a limited data set that does not contain specific, readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

Business Associates: We may disclose PHI to our business associates who perform functions on our behalf or provide us with services, if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

For Public Health or Safety Purposes as allowed or required by law: We may use or disclose PHI when necessary. For example, (1) to prevent a serious threat to the health and safety of a person or public, (2) to prevent or control disease, injury or disability, (3) to report vital statistics such as births and deaths, (4) to notify people of recalls of products that may be using, (5) to report suspected abuse, neglect or domestic violence to public authorities, (6) to report reactions to medications or problems with medical products, (7) for purposes related to the quality, safety or effectiveness of an FDA-regulated product, (8) to a school related to proof of immunization.

Uses and Disclosures that May be Made without Your Authorization, But for Which You have an Opportunity to Object.

Family and Other Persons Involved in Your Care or Payment of Your Care: Unless you object, we may use or disclose PHI to a family member, a relative, a close friend, your personal representative or any other person that you identify, general information of your location, your general condition, or death. If you are present, we will provide you with an opportunity to object to the use or disclosure of your health information prior to such use or disclosure. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. In such a case we will only disclose information that directly relates to that person's involvement in your health care, such as allowing a person to pick up prescriptions, lab requisitions, medical supplies, or other similar forms of health information.

For Disaster Relief Purposes: We may disclose your PHI to disaster relief organizations that seek your PHI in order to coordinate notification of family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can.

Uses and Disclosures Requiring Your Written Authorization

Other Uses and Disclosures: All Uses and Disclosures not covered by this Notice or the laws that apply to use 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 revoke any such authorization at any time by submitting a written revocation to our Privacy Officer. If you revoke your authorization you understand that we cannot take back any disclosures that have already been made with your permission prior to the revocation.

Marketing Communications: We must obtain your written authorization prior to using or disclosing PHI for marketing purposes, subject to the definitions and exceptions set forth in HIPAA. We may, however, provide you with marketing materials in a face-to-face encounter without obtaining your written authorization. We may also provide refill reminders or otherwise communicate about a drug or biologic that is currently being prescribed without your written authorization. We may communicate with you, without your written authorization, about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.

Sale of PHI: we may not sell your PHI without your written authorization. An exception would be in the case of the transfer of ownership of this business to a new proprietor and the PHI would maintain within the confines of this business entity.

Uses and Disclosure of Your Highly Confidential Information: In addition to the HIPAA Privacy Rule, federal and state laws require special privacy protections for certain highly confidential information about you, 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, (6) is about genetic testing, (7) is about child abuse and neglect, (8) is about domestic abuse of an adult with a disability, (9) is about sexual assault (collectively “Highly Confidential Information”). 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.

YOUR INDIVIDUAL RIGHTS

Your rights under HIPAA Privacy, Security and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act, are as follows:

Right to Inspect and Copy: You may request copies of your medical record and billing records maintained by us. You have the right to request either a paper or an electronic copy of your records. All requests for records must be made in writing. We will make every effort to provide you with access to your records in the form or format that you request, if it is readily reproducible or, if not, in a readable hard copy form or such other form and format as agreed upon. If electronic records are not readily reproducible in the format you request, we may provide them in another electronic format. We have up to 15 business days (unless we request an extension) to respond to your request and we may charge you a reasonable fee for the costs of copying and sending your records. Under limited circumstances, we may deny your access to your records.

Right to Request Confidential 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 to ensure confidentiality. For example, you may request that we contact you by mail at a specific address or call you only at your work number. Your written request must specify how and where you wish us to contact you.

Breach Notification: You have the right to be notified if we discover a breach of your unsecured PHI, according to the requirement under federal law.

Right to Request Restrictions: You have the right to request a restriction or limitation on how we use or disclose PHI for treatment payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or a friend. If you pay in full (out of pocket) for your treatment, you can instruct us not to share information about your treatment with your health plan, unless such disclosure is otherwise required by law. To request a restriction on who may have access to your PHI, you must submit a written request addressed to the Privacy Office at Maple Leaf Dental. 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 request unless you are asking to restrict the use and disclosure of our PHI to your health plan for services for which you have paid us out of pocket in full. If we do agree to the requested restriction we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment and if such use or disclosure occurs we will request that the health care provider not further use or disclose the PHI, or as otherwise permitted or required by HIPAA.

Right to Accounting Disclosures: Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or otherwise authorized by you, and is subject to other restrictions and limitations. It excludes disclosures we made to family members and friends involved in your care or for notification purposes.

Right to Request Amendment: You have the right to request that we amend your health information. You have the right to request that information be added to your record, but you do not have the right to request that information be removed from your record. Your request for amendment must be made in writing, to the Privacy Officer at Maple Leaf Dental, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your request you have the right to file a statement of disagreement with us and we will include this statement in your record.

Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice at any time by contacting our Privacy Officer by phone or mail.

HOW TO EXERCISE YOUR RIGHTS

To exercise any of your rights described in this Notice, send your request in writing to our Privacy Officer at the address below. We may ask you to fill out a form that we supply.

If you desire further information about your privacy rights, or are concerned about the handling of your privacy rights, you may contact our Privacy Officer by calling 206-402-3402 or submit your request in writing to: Privacy Officer, Maple Leaf Dental, 7750 15th Ave NE, Ste A, Seattle, WA 98115.

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, call 877-696-6775 toll free or mail it to: Secretary of the US Department of Health and Human Services, 200 Independence Ave SW, Washington DC, 20201.

You may also go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa for more information.

We respect your right to file a complaint with us or with the US Secretary of Health and Human Services and we will not retaliate against you for filing such a complaint.

EFFECTIVE DATE AND CHANGES TO THIS NOTICE

The Notice was effective on October 28, 2011 and was revised on February 13, 2020.

Changes to this Notice: We reserve the right to change the terms of this Notice at any time, without prior notification to our patients. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we may create or receive in the future. We will have a copy of the current Notice available in the waiting area of our office and on our website. This notice will contain the effective date. You may obtain any revised notice by contacting the Privacy Officer at 206-402-3402.

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