Notice of Privacy Practices

Office of Ghina Morad DMD

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

** Conditions and limitations may apply; obtain additional information from the front desk.*

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Ghina Morad DMD

Patient Information

Name ______________________________ Telephone _________________________________

Address ____

I, _________________________acknowledge that I have received a copy of this office Notice of Privacy Practices.

Signature ________________________________ Date ______________________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: ____

Relationship to Patient: ____

For Office Use Only

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

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us for obtaining acknowledgement

_____ Other (Please Specify)

NOTICE TO CONSUMERS
Dentists are licensed and regulated by the
Dental Board of California
(877) 729-7789 www.dbc.ca.gov