ANDREW M. SICKLICK
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PRIVACY POLICY AND AUTHORIZATION FORM

As you are aware, the United States Department of Health and Human Services has issued comprehensive regulations relating to the privacy of patient records, commonly known as HIPAA.

Your (or your child's) protected health information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) as well as visual records (i.e. photographs, models, radiographs) may be used or disclosed by us in one or more of the following respects:

-To other health care providers (i.e. your general dentist, oral surgeon, etc.) and adjuncts (i.e. dental or orthodontic laboratories) in connection with our rendering orthodontic treatment to you (or your child) (i.e. to determine the results of cleanings, surgery, etc.);
-To third party payers or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e. to determine benefits, dates of payments, etc.)
-To certifying, licensing, and accrediting bodies in connection with obtaining certification, licensure, or accreditation;
-To dentists or students for purposes of research and/or education;
-Internally, to all staff members who have any role in your treatment;
-To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
-To your family and close friends involved in your treatment, and/or
-We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. These reminders may be left as messages on an answering machine, voice mail, or with a person answering a phone number given to us by you.

Under the privacy rules, you have the right to:

-Request restrictions on the use and disclosure of your protected health information,
-Request confidential communication of your protected health information,
-Inspect and obtain copies of your protected health information thorugh asking us,
-Amend or modify your protected health information in certain circumstances, and
-Receive an accounting of certain disclosures made by us of your protected health information

We will strive to satisfy your needs and concerns, as reasonably as possible, and as required by law.

This privacy notice is effective as of the date of your introduction to our practice, and confirmed by your signature. Please direct any questions to our Privacy Contact Person, Dr. Andrew Sicklick.

Patient Acknowedgment

I hereby acknowledge that I have received a copy of this privacy notice.

_____(parent or guardian) _____(date)