THE DENTAL CENTER OF EAGAN PRIVACY NOTICE

This notice is required by the new patient privacy regulations issued by the United States Department of Health and Human Services ("HHS"), and describes how your medical information may be used or disclosed, and how you may gain access to your medical information.

Your protected medical information (i.e. individually identifiable information, such as names, dates, phone/fax numbers, email addresses and demographic data) 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, orthodontists, etc.) in connection with our rendering oral surgery treatment to you;
- 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;
- To certifying, licensing and accrediting bodies (i.e., the American Board of Oral Surgeons, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment; and/or
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.

Under the new 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 through asking us;
- Amend or modify your protected health information;
- Receive an accounting of certain disclosures made by us of your protected health information; and
- You may file a complaint with the HHS Secretary as to any violation by us of your privacy rights, which must be filed within 180 days of the violation.

We have the following duties under the privacy rules:

- To only utilize your protected health information as set forth in the attached Consent and/or Authorization;
- To obtain your written consent to use your protected patient information for treatment, payment or health care operations, and to refuse treatment if you refuse to sign the consent;
- To obtain your written authorization to use your protected patient information for any purpose other than treatment, payment or health care operations;
- To use reasonable effort to limit the amount of protected health information that is used, disclosed or requested to the minimum degree necessary where such information is used, disclosed or requested for purposes other than treatment; and,
- To obtain satisfactory assurances from our business associates who render services to our office that your protected health information will be safeguarded by them.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be overheard by other patients and third parties.

If you have any questions about the information in this Notice, please let us know. Thank you.

PATIENT PRIVACY CONSENT

This form is required by the new patient privacy regulations recently issued by the United States Department of Health and Human Services. Prior to commencing your oral surgery treatment, you must review, sign and date this form.

Your protected health information may be used in connection with your treatment, payment of your account or health care operations.

We will maintain a good faith effort to protect your privacy as stated in our privacy notice. You have a right to review our policy before signing this consent. This consent authorizes us to treat the patient, release information as needed to treat the patient and release information to seek payment for treatment.

You have a right to request restriction or revoke use of your protected health information at any time with written request.

PATIENTS NAME_____DATE_____