

# NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how healthcare information about you may be used by Katelyn Johnson, D.M.D, A full notice of your privacy rights have been provided to you.

**Treatment, Payment, Operations.** We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

**Uses and Disclosures for Appointment Reminders.** We may use and disclose your healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

**Authorization for Use and Disclosure.** 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.

**Public health, research, health and safety, government, workers compensation.** We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

**Rights.** You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

**Organization duties.** We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

“I acknowledge that I have received the full Privacy Notice.”

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Name (print)	Signature	Date
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Witness Name (Print)	Signature	Date
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