Timothy C Rothrock DDS, PA
1308 S Pleasant St Springdale, AR 72764
479-751-5071
www.smilesbyrothrock.com

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCOLSURES OF HEALTH INFORMATION- We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.
Required By Law/ National Security: We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities your health information to armed service personnel under certain circumstances. We may disclose to authorized federal officials your health information required for lawful intelligence, counterintelligence, or other national security activities. We may also disclose your health information to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.
Abuse or Neglect: We may disclose your health information 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. We may disclose your health information to the extent necessary to avert a serious threat to your health or the safety or health or safety of others.

PATIENT RIGHTS
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request:

- The right to request restrictions on certain uses and disclosures of protected health information
- The right to reasonable requests to receive confidential communications from us by alternative means or locations.
- The right to inspect & copy your protected health information
- The right to amend your protected health information
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a copy of this notice of request.

We reserve the right to change the terms of our Notice of Privacy Practices from time to time to make new notice provisions effective for all protected information that we maintain. If you feel that your privacy protections have been violated, you have the right to file a complaint with this office or with the Department of Health and Human Services. We will not retaliate against you for making a complaint. If you have any questions about HIPPA, would like to request restrictions on your personal information please contact us.

PATIENT CONSENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information will be used to conduct, plan, and direct my treatment, obtain payment, and conduct normal healthcare operations. I have read & or received a copy of the more complete Notice of Privacy Practices and understand that Dr Rothrock has the right to change the notice from time to time. I understand that I may request in writing that you restrict how the information is used. I also understand that you are not required to agree to the restrictions but if you do agree you must abide by the restrictions. I also understand that I may revoke this consent in writing at any time.

Print Name_____

Signature_____**Date**_____