

# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This act gives you, the patient, significant rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would include referring to a specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilizing review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, including functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

**Venetian Dental**  
**Dr. Alexander Gaukhman, DMD, P.A.**

**ACKNOWLEDGEMENT OF RECEIPT OF JOINT NOTICE OF  
PRIVACY PRACTICES**

**I have received a copy of the joint Notice of Privacy Practices of Venetian Dental and Dr. Alexander Gaukhman DMD, P.A.**

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**Please Print Name**

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**Signature**

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**Date**

**\*You may refuse to Sign This Acknowledgment\***

**For Office Use Only**

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

- Individual refused to sign**
- Communication barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgement**
- Other (Please Specify):**

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