POLESKI FAMILY DENTISTRY

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Notification of Privacy Policy

This notice describes how personal medication information about you may be used and disclosed. Please review it carefully.

Dr. Kenneth M Poleski is required by law to maintain the privacy and confidentiality of your protected health information and to provide his patients with notice of legal duties. We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations. We may disclose your health information to your insurance provider for the purpose of payment. We may disclose your information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition in the event of an emergency.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling diseases, injury or disability; reporting child abuse or neglect; reporting domestic violence; and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to a law enforcement official. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to health or safety to the general public.

You have the right to request restrictions on uses and disclosures of your health information; however, Dr. Kenneth M Poleski is not required to agree to the restrictions you may request. You have the right to inspect and copy your information. You have the right to a paper copy of this disclosure at any time.

This notice is effective as of April 1, 2016.

I have read this Notification of Privacy Policy and understand my rights contained in this notice. By way of my signature, I provide Dr. Kenneth M Poleski with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and health care operations.

Printed Name _____ Date_____

Patient Signature_____

If you would like us to share any personal information, including appointments, finances, treatment planned and treatment performed, with anyone besides yourself, please identify that person below.

Name_____ Relationship _____