



Shelburne
Village DENTISTRY

NOTICE OF PRIVACY PRACTICES (HIPAA)

Effective Date: January 1, 2026

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.

OUR COMMITMENT TO YOUR PRIVACY

We understand that your health information is personal. We are committed to protecting your Protected Health Information (PHI). This Notice describes how we may use and disclose your information and your rights regarding that information.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

We may use and disclose your PHI for the following purposes:

Treatment

We may use your information to provide, coordinate, or manage your dental care and related services, including sharing information with specialists, laboratories, and other healthcare providers.

Payment

We may use and disclose your information to obtain payment for services provided, including submitting claims to insurance companies.

Healthcare Operations

We may use your information for office operations such as quality assessment, staff training, licensing, and administrative functions.

ADDITIONAL USES AND DISCLOSURES

We may also disclose your information: - As required by law - For public health activities - For health oversight activities - For law enforcement purposes (when legally required) - To avert a serious threat to health or safety

REPRODUCTIVE HEALTH PRIVACY PROTECTIONS

We will not use or disclose your reproductive health information for the purpose of conducting or supporting investigations, legal actions, or law enforcement activities related to legally obtained reproductive healthcare.

When required, we will obtain a valid attestation before disclosing such information.

YOUR RIGHTS

You have the following rights regarding your health information:

Right to Access

You have the right to inspect and obtain a copy of your records in paper or electronic form. We will respond within 30 days.

Right to Request Restrictions

You may request restrictions on certain uses and disclosures. If you pay out-of-pocket in full for a service, you may request that we not disclose that information to your insurance company, and we will honor that request as required by law.

Right to Confidential Communications

You may request that we contact you in a specific way (e.g., home phone, work phone, email, or alternate address). We will accommodate reasonable requests.

Right to Amend

You may request that we amend your health information if you believe it is incorrect or incomplete.

Right to an Accounting of Disclosures

You have the right to request a list of certain disclosures we have made of your information.

Right to a Copy of This Notice

You have the right to receive a paper copy of this Notice at any time.

ELECTRONIC COMMUNICATIONS

We may contact you via phone, text message, email, or patient portal for appointment reminders, treatment information, or billing purposes. These methods may involve some level of risk. You may opt out of these communications at any time.

BREACH NOTIFICATION

In the event of a breach of your unsecured PHI, we will notify you as required by law. This notification will include details about the breach and steps you can take to protect yourself.

MARKETING AND SALE OF INFORMATION

We will not use or disclose your health information for marketing purposes or sell your information without your written authorization.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. Any changes will apply to all information we maintain. The updated Notice will be available in our office and upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

CONTACT INFORMATION

Privacy Officer: Karen Drewniak Practice Name: Shelburne Village Dentistry Phone: 802-985-9700 Email: office@shelburnevillagedentistry.com Address: 41 Falls Rd., Shelburne, VT 05482

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of this Notice of Privacy Practices.

Patient Name: _____ Signature: _____

Date: _____