**Cary Lee Family Dentistry
1500 Piney Plains Road Suite 101
Cary, NC 27518**

Notice of Privacy Practices:

I understand that my health care information concerning my diagnosis, treatment, payment and insurance will be disclosed when necessary for filing my insurance and in communication with other health care professionals in the course of treatment in their offices. Limited information will also be disclosed to businesses supporting operations of this office such as dental or medical labs, hospitals, accountants, billing personnel, computer support, answering service, consultants, and/or referrals to other doctors or clinics.

In some limited situations the law allows or requires us to use or disclose your health information without permission such as for public health purposes, for health oversight activities, for judicial and administrative proceedings, for law enforcement purposes, for a medical examiner, to prevent a serious threat to health or safety, for worker’s compensation programs, etc.. If a family member or person is paying for your health care with your knowledge, we may disclose your information to that person.

I understand that my files are stored on a computer database. Only staff have access to this office during non-business hours. I understand that this office will make every effort to keep my information secure and correct any violation of my privacy if this should ever occur.

I understand that I have the right to access, copy or inspect my healthcare information, to restrict disclosures, and to obtain an accounting of disclosures. I have the right to voice my concerns about privacy to the practice and/or the Secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by the office. I may correct my records in the form of a letter signed by myself. I also have the right to revoke my authorization for disclosure.

I understand that I will receive communication in my preferred method to remind me of an existing or future appointment. Communication may also be sent to me in the form of fax, emails, or other electronic means. Complete messages concerning my health information may be left on my personal phone or work voicemail.

I have read and understand this office policy. I understand that by signing this agreement, I give permission for the use and disclosure of my personal and health information in order to carry out treatment, payment, insurance claims, and healthcare operations. This office retains the right to revise the privacy policy.

Patient/Guardian Signature:
Date Signed:
I have read this form and do not wish to sign: (Initial)