Ramin Razavi , DMD, MS
Patient Privacy Policy
Effective: April 15, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABLILITY ACT. (HIPAA)

PLEASE REVIEW THIS NOTICE CAREFULLY

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice.

We realize that these laws are complicated, but we must provide you with the following important information.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

- **Confidential Communications**. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. We will accommodate all reasonable requests.
- **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations and restrict our disclosure of your health information to only certain individuals involved, such as family members and friends. **We are not required to agree to your request**. In order to request a restriction in our use or disclosure of your health information, you must make your request in writing.
- **Inspection and Copies**. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records.
- **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice.
- **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your health record for non-treatment, non-payment or non-operations purposes.
- **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.
- **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.
- **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health record may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your health record for the reasons described in the authorization. Please note, we are required to retain records of your care.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION IN THE FOLLOWING WAYS

1. **Treatment**. Our practice may use your health record to treat you. For example, we might disclose your health record to a pharmacy when we order a prescription for you or to others who may assist in your care, such as your spouse, children or parents and, other health care providers for purposes related to your treatment.
2. **Payment**. Our practice may use and disclose your health record in order to bill and collect payment. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover,

or pay for, your treatment. We also may use and disclose your health record to obtain payment from third parties that may be responsible for such costs, such as family members and government and legal agencies.

3. **Health Care Operations**. Our practice may use and disclose your health record to operate our business to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice
4. **Appointment Reminders**. Our practice may use and disclose your health record to contact you and remind you of an appointment.
5. **Treatment Options**. Our practice may use and disclose your health record to inform you of potential treatment options or alternatives.
6. **Release of Information to Family/Friends**. Our practice may release your health record to a friend or family member that is involved in your care, or who assists in taking care of you. (e.g., elderly patients with special needs; caretakers of minors or disabled persons).

The following categories describe unique scenarios in which we may use or disclose your health information:

- **Disclosures Required By Law**
- **Law Enforcement/Correctional Institution**
- **Serious Threats to Health or Safety**
- **National Security**
- **U.S. Military or Foreign Military Forces (including veterans)**
- **Public Health Risks**
- **Workers' Compensation/Similar Programs**
- **Health Oversight Activities**
- **Lawsuits and Similar Proceedings**

The terms of this notice apply to all records containing your health record that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE; WOULD LIKE A COPY OF IT; OR HAVE A SPECIFIC REQUEST REGARDING RESTRICTING THE USE OF ANY PORTION OF YOUR HEALTH RECORD, PLEASE MAKE A WRITTEN REQUEST TO: Ramin Razavi, DMD, MS 6829 Elm Street, Suite# 320 McLean, VA 22101 telephone: 703-288-0100.

I, _____, have received a copy of Dr. Ramin Razavi's Notice
Patient name [please print]

of Privacy Practices.

_____ (please circle) _____
Signature of Patient/ Parent/Legal Guardian of a Minor Date

RAMIN RAZAVI, DMD, MS
6829 ELM STREET SUITE 320
McLEAN, VIRGINIA 22101
703-288-0100

LIFETIME AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE DR. RAMIN RAZAVI TO APPLY FOR THE BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM MY DENTAL AND MEDICAL SERVICE MEDICARE PART B, AND ALL OTHER THIRD PARTY CARRIERS, BE MADE DIRECTLY TO DR. RAMIN RAZAVI. I CERTIFY THT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM TO DENTAL/MEDICAL SERVICE MEDICARE PART B, AND ALL OTHER THIRD PARTY CARRIERS. MY PERMISSION IS GIVEN TO USE A COPY OF THIS AUTHORIZATION IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY EITHER ME OR DENTAL/MEDICAL SERVICES OF VIRGINIA AT ANY TIME, PROVIDED IT IS DONE IN WRITING.

I UNDERSTAND THIS IS A LIFETIME AUTHORIZATION AND CAN ONLY BE REVOKED BY ME OR DENTAL MEDICAL SERVICES OF VIRGINIA IN WRITING.

AUTHORIZED SIGNATURE OF
PATIENT/GUARDIAN:_____
DATE:_____