Notice of Privacy Practices

This notice describes how medical information about you or your child may be used and disclosed an how you can get access to this information. Please review it carefully.

I. Dental Practice Covered by this Notice

This notice describes the privacy practices of Ghosh Orthodontics ("Dental Practice"). "We" and "our" means the Dental Practice. "You" and "your" means our patient.

II. How to Contact Us/Our Privacy Officer

If you have any questions or would like further information about this Notice, you can contact Chord Specialty Dental Partner's Privacy Officer at:

Privacy Officer
1801 West End Ave., Suite 410
Nashville, TN 37203
(484) 787-2943
compliance@chordsdp.com

III. Our Promise to You and Our Legal Obligations

The privacy of your health information is important to us. We understand that your health information is personal, and we are committed to protecting it. This Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to:

- Maintain the privacy of your protected health information
- Give you this Notice of our legal duties and privacy practices with respect to that information, and
- Abide by the terms of our Notice that is currently in effect.

IV. Last Revision Date

This Notice was last revised on February 1, 2025.

V. How We May Use or Disclose Your Health Information

The following examples describe different ways we may use or disclose your health information. These examples are not meant to be exhaustive. We are permitted by law to use and disclose your health information for the following purposes:

i. Common Uses and Disclosures

a. Treatment – We may use your health information to provide you with dental treatment or services, such as cleaning r examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.

b. Payment – We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.

c. Health Care Operations – We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services,

training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.

d. Appointment Reminders – We may use or disclose your health information when contacting you to remind you of a dental appointment or to schedule a future appointment. We may contact you by using a postcard, letter, phone call, voice message, text, or email.
e. Disclose to Family Members and Friends – We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.
f. Disclosure to Business Associates – We may disclose your protected health information to our third-party service providers (called "business associates") that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use a business associate to assist us in maintaining our practice management software. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

ii. Less Common Uses and Disclosures

a. Disclosures Required by Law – We may use or disclose patient health information to the extent we are required by law to do so. For example, we are required to disclose patient health information to the U.S. Department of Health and Human Services so that it can investigate complaints or determine our compliance with HIPAA.
b. Public Health Activities – We may disclose patient health information for public health activities and purposes, which may include: preventing or controlling disease, injury or disability, reporting births or deaths, reporting child abuse or neglect, reporting adverse reactions to medications or foods, reporting product defects; enabling product recalls, and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
c. Victims of Abuse, Neglect, or Domestic Violence – We may disclose health information to the appropriate government authority about a patient whom we believe is a victim of abuse, neglect, or domestic violence.
d. Health Oversight Activities – We may disclose patient health information to a health oversight agency for activities necessary for the government to provide appropriate oversight of the health care system, certain government benefit programs, and compliance with certain civil rights laws.
e. Lawsuits and Legal Actions – We may disclose patient health information in response to (i) a court or administrative order or (ii) a subpoena, discovery request, or other lawful process that is not ordered by a court if efforts have been made to notify the patient or to obtain an order protecting the information requested.
f. Law Enforcement Purposes – We may disclose your health information to a law enforcement official for a law enforcement purpose, such as to identify or locate a suspect, material witness, or missing person, or to alert law enforcement of a crime.
g. Coroners, Medical Examiners, and Funeral Directors – We may disclose your health information to a coroner, medical examiner, or funeral director to allow them to carry out their duties.
h. Organ, Eye, and Tissue Donation – We may use or disclose your health information to organ procurement organizations or others that obtain, bank, or transplant cadaveric organs, eyes, or tissue for donation and transplant.
i. Research Purposes – We may use or disclose your information for research purposes pursuant to patient authorization waiver approval by an Institutional Review Board or Privacy Board.

j. Serious Threat to Health or Safety – We may use or disclose your health information if believe it is necessary to do so to prevent or lessen a serious threat to anyone's health or safety.
k. Specialized Government Functions – We may disclose your health information to the military (domestic or foreign) about its members or veterans, for national security and protective services for the President or other heads of state, to the government for security clearance reviews, and to a jail or prison about its inmates.
l. Workers' Compensation – We may disclose your health information to comply with workers' compensation laws or similar programs that provide benefits for work-related injuries or illnesses.

VI. Your Written Authorization for Any Other Use or Disclosure of Your Health Information

Uses and disclosures of your protected health information that involve the release of psychotherapy notes (if any), marketing, sale of your protected health information, or other uses or disclosures not described in this notice will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, in writing, except to the extent that this office has taken an action in reliance on the use of disclosure indicated in the authorization. If a use or disclosure of protected health information described above in this Notice is prohibited or materially limited by other laws that apply to use, we intend to meet the requirements of the more stringent law.

VII. Your Rights with Respect to Your Health Information

You have the following rights with respect to certain health information that we have about you (information in a Designated Record Set as defined by HIPAA). To exercise any of these rights, you must submit a written request to our Privacy Official listed on the first page of this Notice.

i. Right to Access and Review – You may request to access and review a copy of your health information. We may deny your request under certain circumstances. You will receive written notice of a denial and can appeal it. We will provide a copy of your health information in a format you request if it is readily producible. If not readily producible, we will provide it in a hard copy format or other format that is mutually agreeable. If your health information is included in an Electronic Health Record, you have the right to obtain a copy of it in an electronic format. We may charge a reasonable fee to cover our cost to provide you with copies of your health information.
ii. Right to Amend – If you believe that your health information is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances. You will receive written notice of a denial and can file a statement of disagreement that will be included with your health information that you believe is incorrect or incomplete.
iii. Right to Restrict Use and Disclosure – You may request that we restrict uses of your health information to carry out treatment, payment, or health care operations or to your family member or friend involved in your care of the payment for your care. We may not (and are not required to) agree to your requested restrictions, with one exception; If you pay out of your pocket in full for a service you receive from us and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request.
iv. Right to Confidential Communications, Alternative Means and Locations – You may request to receive communications of health information by alternative means or at an alternative location. We will accommodate a request if it is reasonable, and you indicate that communication by regular means could endanger you. When you submit a written request to the Privacy Official listed on the first page of this

Notice, you need to provide an alternative method of contact or alternative address and indicate how payment for services will be handled.

v. Right to an Accounting of Disclosures – You have a right to receive an accounting or disclosures of your health information for the six (6) years prior to the date that the accounting is requested except for disclosures to carry out treatment, payment, health care operations (and certain other exceptions as provided by HIPAA). The first accounting we provide in any 12-month period. We will notify subsequent request for an accounting within the same 12-month period. We will notify you in advance of this fee and you may choose to modify or withdraw your request at that time.

vi. Right to a Paper Copy of this Notice – You have the right to a paper copy of this Notice. You may ask us to give you a paper copy of the Notice at any time (even if you have agreed to receive the Notice electronically). To obtain a paper copy, ask the Privacy Official.

vii. Right to Receive Notification of a Security Breach – We are required by law to notify you if the privacy or security of your health information has been breached. The notification will occur by first class mail within sixty (60) days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of your health information. The breach notification will contain the following information: (1) a brief description of what happened, including the date of the breach and the date of the discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

viii. Special Protections for HIV, Alcohol, and Substance Abuse, Mental Health, and Genetic Information – Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including HIV-related information, alcohol, and substance abuse information, mental health information, and genetic information. For example, a health plan is not permitted to use or disclose genetic information for underwriting purposes. Some parts of this HIPAA Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact our office for more information about these protections.

ix. Our Right to Change Our Privacy Practices and This Notice – We reserve the right to change the terms of this Notice at any time. Any change will apply to the health information we have about you or create or receive in the future. We will promptly revise the Notice when there is a material change to the uses or disclosures, individual's rights, our legal duties, or other privacy practices discussed in this Notice. We will post the revised Notice on our website (if applicable) and in our office and will provide a copy of it to you on request.

VIII. How to Make Privacy Complaints

If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Officer listed on the first page of this Notice. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you in any way if you choose to file a complaint.

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

Acknowledgement of Receipt of HIPAA Privacy Practices

Please read the following statement carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your (your child's) protection health information to carry out treatment, payment activities, and healthcare operations. You also acknowledge that you have been provided with access to a copy of the company's Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. This notice provides a description of how your (your child's) information is used to ensure treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time from the dental office, our website, or by contacting the Privacy Officer:

Title: Privacy Officer
Address: 1801 West End Ave., Suite 410, Nashville, TN 37203

Changes to Privacy Practices: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your (your child's) protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you (your child) if you revoke this consent.

Acknowledgement

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent for the use and disclosure of my (my child's) protected health information to carry out treatment, payment activities and health care operations, as described in the Notice of Privacy Practices.

Patient's Name: _____ DOB (MM/DD/YY): _____

Signatory's Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices; however, 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): _____

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

HIPAA Authorization for Release of Health Information

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

Purpose of Form: This form is used to authorize the release of Protected Health Information (PHI) to certain individuals and/or entities. By submitting this form, I acknowledge that I understand and agree that:

- This authorization is voluntary and will expire one (1) year from the date of patient's last visit. I may revoke this authorization at any time but must do so in a writing submitted to the practice, and the revocation will not apply to information that has already been released.
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.
- I may not be denied treatment if I do not sign this form, except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations.

Who May Receive and Disclose Your Information: I authorize the disclosure of my individually identifiable health information to the following individual(s) and/or organization(s).

Name	Area Code + Phone #	Relationship to Patient	Type of Information	Comments
			☐ All health information ☐ Other: See Comments	
			☐ All health information ☐ Other: See Comments	
			☐ All health information ☐ Other: See Comments	
			☐ All health information ☐ Other: See Comments	

The type(s) of information identified above may be disclosed to the individual(s) and/or organization(s) identified below:

☐ At my request or the request of the individual or organization

☐ Only for the following purpose(s): _____

(No purpose need be stated if the request is made by the patient and the patient does not wish to state the purpose)

Acknowledgement: I understand that:

- The named company may not be required to agree to the restriction(s) requested. Even if the restriction is denied, patients and their authorized representatives will generally have an opportunity to agree or object prior to disclosures to persons involved in patient care. If the named company agrees to a requested restriction, it will be binding except in the case of emergency treatment. If restricted information is released for emergency treatment, the named company will request the provider not to further use and/or disclose that information.
- I may make a request for confidential communications of my health information by alternative means or to an alternative location. However, I understand that such request is applicable only to information held by the named company and disclosure by alternative means may not be protected and could endanger me. I understand that requests for electronic communications (such as by fax and email) may be intercepted by others and the named company is not responsible if such intercepts occur.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Printed Name of Patient or Patient's Representative Relationship to Patient (if applicable)

YOU ARE ENTITLED TO A COPY OF THIS DOCUMENT

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

Records Request - Authorization for Release of Patient Records

Patient Information

Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Record Release and Delivery

I would like to receive my records in the following delivery format (*please check all that apply*):

- ☐ Home Delivery (*if address is same as above*)
- ☐ E-Mail* _____
- ☐ In-Person Pickup
- ☐ Send to Another Recipient
- ☐ Recipient Fax*: _____
- ☐ Recipient E-mail*: _____

Recipient Name: _____
Mailing Address: _____
City: _____
State: _____ Zip: _____

Records to be Released

- ☐ All Date(s) of Service
- ☐ Following Date(s) of Service: ____/____/_____through ____/_____/_____
- ☐ All Clinical/Dental Records
- ☐ All Radiographs (x-rays)
- ☐ Clinical/Dental Visit Notes
- ☐ Other: _____

Reason for Release

- ☐ Transferring to General Dentist
- ☐ Referral or Specialist
- ☐ Second Opinion
- ☐ Moving/Moved
- ☐ Other: _____

Authorization

By signing this form, I authorize the named company to release the protected health information (PHI) and other records of the patient listed on this form. I further acknowledge that by law the company has up to 30 days to respond to this record request. I understand that there may be a reasonable cost-based fee for a copy of the records that I will have an opportunity to agree or object to. Postage may be added for mail requests.

My authorization will automatically expire one hundred eighty (180) days after the date of signature. I may revoke this authorization at any time, but must do so in writing, and the revocation will not apply to information that has already been released. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing the company to release information as described above.

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

You may submit this form in person or via fax to the facility named in this release or You may submit this form via email to recordsrequest@chordsdp.com

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

Patient Privacy Complaint

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

_____

Description of Violation of Privacy Rights

Describe briefly what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

When do you believe that the violation of health information privacy rights occurred? List date(s):

_____ ☐ Unknown

Have you already shared this information with a company employee? ☐ Yes ☐ No

If yes, please provide the name of the employee(s) notified: _____

Are you filing this complaint for someone else? ☐ Yes ☐ No *If yes*, please provide your contact information:

Name: _____ Relation to Patient: _____

Address: _____ Phone: _____

_____ Fax: _____

You may submit this form via mail, email, or in person to the facility or Privacy Officer

Attn: Privacy Officer
1801 West End Ave., Suite 410
Nashville, TN 37203
compliance@chordsdp.com

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

Request for Accounting of Disclosures

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

_____

I am requesting an accounting of disclosure of ☐ Clinical/Dental Records ☐ Billing Records

During the date range: _____ to _____

☐ All dates within the prior six (6) years of the date this release is signed

Accounting to be Released to:

Name: _____

Address: _____

_____

_____

Fax: _____

Phone: _____

Email: _____

Delivery Method:

☐ In-person pickup at facility (paper)

☐ US Mail (paper)

☐ Fax

☐ Email

By requesting records sent via fax or email, you recognize the inherent risk in sending records electronically, and the company is not responsible for the confidentiality and integrity of data sent to non-secured fax or email recipients.

Acknowledgements

By signing this form, I acknowledge that this accounting of disclosure will include all disclosures **except**:

- to carry out my treatment, process payment for my health care, or carry out the practice's health care business operations
- to the patient, their legal guardian(s), or authorized representative(s)
- those that are incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA
- to persons involved in the patient's care or as part of an inpatient directory
- those pursuant to an authorization for release of information signed by the patient, their legal guardian(s), or authorized representative(s)
- for national security or intelligence purposes, to correctional institutions, or to law enforcement officials under certain circumstances
- to correctional institutions or law enforcement officials under certain circumstances
- as part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health, or certain health care operations purposes

I understand that I may receive the first accounting for disclosures within a 12-month period at no charge. I understand that if I am requesting a second or subsequent accounting in a 12-month period I will be charged a flat fee for this accounting. This fee is to cover the cost of supplies, labor and postage associated with copying. I further understand that, if I do not ask you to proceed with my request, I may modify my request to reduce the fee or withdraw my request and pay no fee.

I understand that the company must provide the accounting of disclosures within 60 days of my request or notify me that a one-time extension of an extra 30 days (or less) is required to prepare an accounting of disclosures.

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

You may submit this form via mail, email, or in person to the facility or Privacy Officer
(Attn: Privacy Officer) 1801 West End Ave., Suite 410, Nashville, TN 37203
compliance@chordsdp.com

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

Request to Amend Record

Patient Name: _____ DOB (MM/DD/YY): _____

Home Address: _____ Phone: _____

_____

I am requesting an amendment of ☐ Clinical/Dental Records ☐ Billing Records

Date of Entry to Be Amended _____

Description of Information to Be Amended

Please provide an explanation how the entry is incorrect/incomplete.

_____

_____

_____

_____

_____

_____

Notification to Other Parties

I authorize the company to make reasonable efforts to notify other parties (providers, facilities, insurance company, etc.) who the company knows received the above information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your healthcare. ☐ Yes ☐ No

Authorization

I understand that only information that is inaccurate and/or incomplete may be amended, and that the company is obligated to deny requests that do not meet requirements set forth by HIPAA law. I understand that the company has 60 days to consider my request for an amendment, and if denied, I will be provided a written explanation of the denial and options for appealing the denial.

Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

You may submit this form via mail, email, or in person to the facility or Privacy Officer

Attn: Privacy Officer
1801 West End Ave., Suite 410
Nashville, TN 37203
compliance@chordsdp.com

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

HIPAA Request for Confidential Alternative Communication of Protected Health Information

Purpose: This form is used to request that the named company provide communication(s) of Protected Health Information (PHI) in an alternate method or manner. You may make this request at any time by giving written notice to the Privacy Contact listed on our Notice of Privacy Practices. You may only request a confidential or alternative manner or method of PHI communication for yourself or if you are the personal representative of a patient.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Medical Record #: _____

***If being requested by a Personal Representative (parent, guardian, power of attorney)*

Representative's Name: _____ Relationship to Patient: _____

2. REQUEST

I hereby request to receive confidential or alternative communication(s) from the named company regarding my health condition; care, treatment, services, and/or payment by an alternative manner (check all that apply):

☐ At a telephone number other than the primary number in my record: _____

☐ At a mailing address other than my home mailing address.

Preferred mailing address: _____

_____

_____

☐ Other. Please specify: _____

3. SIGNATURE

I understand that if the named company agrees to provide me with confidential communications regarding my health care via the above alternative manner and method, the named company may condition this agreement upon the following:

a. The receipt of information from me as to how payment for named company services will be handled.
b. The specification of an alternative address or other method of contact.

Signature: _____ **Date:** _____

GHOSH ORTHODONTICS

FOR OFFICE USE

Patient ID#: _____

HIPAA Revocation of Request for Confidential Alternative Communication of Protected Health Information

Purpose: This form is used to revoke or to confirm revocation of a previous Request for Confidential or Alternative Communication of PHI. You may make this revocation at any time by giving written notice to the Privacy Contact listed on our Notice of Privacy Practices. You may only revoke a Request for Confidential or Alternative Communication of PHI you made for yourself or when serving as the patient's personal representative. This revocation will not affect any action we took in reliance on an initial Request for Confidential or Alternative Communication of PHI prior to receiving this revocation notice.

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Medical Record #: _____

***If being requested by a Personal Representative (parent, guardian, power of attorney)*

Representative's Name: _____ Relationship to Patient: _____

2. STATEMENT OF REVOCATION

I revoke my Request for Confidential or Alternative Communication for the use and/or disclosure of my protected health information.

I understand that this revocation will not affect any action the named company or others took in reliance on my previous Request for Confidential or Alternative Communication of PHI and before receipt of this written revocation.

Date of the Request for Restriction (if known): _____ / _____ / _____

Specific description of the request for restriction to be revoked (ex: Fax all reports to my personal fax number xxx-xxx-xxxx):

_____

_____

3. SIGNATURE

To be valid, this Revocation of Request for Confidential or Alternative Communication must be signed and dated by the person listed in Section 1.

I, _____, have had full opportunity to read and consider the contents of this Revocation of Request for Confidential or Alternative Communication.

Signature: _____ **Date:** _____