



Newport Center Dental Group

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(949) 640-1122

NOTICE OF PRIVACY PRACTICES

Effective Date: January 21, 2026

THIS NOTICE DESCRIBES HOW DENTAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by law to maintain the privacy of your protected health information ("PHI"), to provide you with this Notice of Privacy Practices, to follow the terms of this Notice currently in effect, and to notify you if a breach of your unsecured PHI occurs.

Protected Health Information includes information that identifies you and relates to your past, present, or future physical or mental health condition, the provision of health care to you, or payment for that care.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

- Treatment:** We may use and disclose your health information to provide, coordinate, or manage your dental care. This includes sharing information with dentists, hygienists, dental specialists, laboratories, or other healthcare providers involved in your treatment.
- Payment:** We may use and disclose your health information to bill and collect payment from insurance companies, dental benefit plans, or other responsible parties.
- Health Care Operations:** We may use and disclose your health information for practice operations, including quality assessment, staff training, licensing, audits, accreditation, business planning, and administrative purposes.

OTHER USES AND DISCLOSURES PERMITTED OR REQUIRED BY LAW

We may disclose your health information without your authorization in the following situations:

- As required by federal, state, or local law
- For public health activities
- For health oversight activities such as audits or investigations
- In response to a court order, subpoena, or lawful request
- For law enforcement purposes
- To prevent or lessen a serious threat to health or safety
- For workers' compensation or similar programs

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not use or disclose your health information for purposes other than those described in this Notice unless you provide written authorization. This includes:

- Marketing purposes
- Sale of your health information

You may revoke your authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Get a Copy of Your Records:** You may inspect or request a copy of your dental and billing records. We will provide access within 30 days as required by law.
- Request Corrections:** You may request an amendment if you believe your health information is incorrect or incomplete.
- Request Confidential Communications:** You may request that we contact you in a specific way or at a specific location.
- Request Restrictions:** You may request limits on how we use or disclose your information. We are not required to agree to all requests.
- Receive a List of Disclosures:** You may request an accounting of certain disclosures of your health information.
- Get a Paper Copy of This Notice:** You may request a paper copy of this Notice at any time, even if you agreed to receive it electronically.
- File a Complaint:** You may file a complaint 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 retaliated against for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the revised notice effective for all health information we maintain. Updated notices will be available in our office and on our website.

CONTACT INFORMATION

If you have questions about this Notice or wish to exercise your rights, please contact:

Privacy Officer: Kristy M.

Dental Office Name: Newport Center Dental Group

Phone: (949) 640-1122

Address: 1401 Avocado Ave., Suite 404, Newport Beach, CA 92660

You may also contact:

U.S. Department of Health and Human Services

Office for Civil Rights

1-877-696-6775

ACKNOWLEDGMENT OF RECEIPT

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

Patient Name: _____

Signature: _____

Date: _____