Matthew Bagnulo, DDS | Family Dentist

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessments.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgement in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, leaving messages at home, work cell and/or by e-mail. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request and amendment to your protected health information. We may, however, deny your request in certain situations.

NOTICE OF PRIVACY PRACTICES (HIPAA), CONT.

- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operation or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by laws to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 3, 2026, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact us:
Dr. Matthew Bagnulo, DDS
Office Manager and Privacy Officer
11830 NE 128th St. #202
Kirkland, WA 98034
425-821-9000

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave S.W.
Washington, D.C. 20201

877-696-6775

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the use of disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Authorization for Disclosure of Substance Use Disorder Records (42 CFR Part 2)

This authorization applies to Substance Use Disorder (SUD) records protected under 42 CFR Part 2 and applicable Washington State law.

By signing this form, I authorize the disclosure of my substance use disorder records, if any, that are included in my dental or healthcare record, for purposes of treatment, payment, and healthcare operations, as permitted by law.

I understand that 42 CFR Part 2 prohibits unauthorized redisclosure of these records without my specific written consent, except as allowed by law.

I understand that I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

This authorization will expire one (1) year from the date of signature, unless a different expiration date or event is specified below:

Expiration date or event (if applicable): _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE, CONT.

I understand that I am not required to sign this authorization as a condition of receiving dental treatment or benefits, except as permitted by law.

Date: _____

Patient's name: _____

Patient's signature: _____

Relationship to patient: _____

Dependent family members also covered by this acknowledgement (do not include spouse or children over the age of 18): _____

☐ I authorize disclosure of Substance Use Disorder records protected by 42 CFR Part 2.

For office use only:
We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- The patient refused to sign
- Communication barriers
- Emergency situations
- Other