



**Huayang John Wu, DDS, Inc.**  
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**NOTICE OF PRIVACY PRACTICES**

**HOW YOUR HEALTH INFORMATION MAY BE USED TO PROVIDE TREATMENT**

We will use your HEALTH INFORMATION within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimized scheduling and coordination of care between dental assistants, dentist and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

**TO CONDUCT HEALTH CARE OPERATIONS**

Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training progress for students, interns, associates and business and clinical employees. It is also possible that health information will be disclosed during audits by Insurance Companies, or government appointed agencies as part of their quality assurance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

**INPATIENT REMINDERS**

Because we believe regular care is very important to your oral and general health we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy or participating with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (**unless you tell us that you do not want to receive these reminders**).

**ABUSE OR NEGLECT**

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment when we believe we are specifically required by law or with the patient's agreement.

**PUBLIC HEALTH AND NATIONAL SECURITY**

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public could benefit if the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

**FOR LAW ENFORCEMENT**

As permitted or required by the State or Federal law we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

**FAMILY, FRIENDS AND CAREGIVERS**

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Other than what is stated above or where Federal, State or Local law requires us we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

**PATIENT RIGHTS**

This new law is careful to describe that you have the following rights related to your health information:

**RESTRICTIONS**

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patient.

**CONFIDENTIAL COMMUNICATIONS**

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other than family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

**INSPECT AND COPY YOUR HEALTH INFORMATION**

You have the right to read, review and copy your health information including your complete chart, x-ray and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

**AMEND YOUR HEALTH INFORMATION**

You have the right to update your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our processes, please

provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be complete.

**DOCUMENTATION OF HEALTH INFORMATION**

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

**REQUEST A PAPER COPY OF THIS NOTICE**

You have the right to obtain a copy of this notice of privacy practices directly from our office at anytime. Stop by or give us a call and we will mail, or email a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this notice of our privacy practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms in our notice. If we change our privacy practices, we will be sure all patients receive a copy of the revised notice. You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns and complaints in writing.

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**PATIENT ACKNOWLEDGEMENT**

Patient Name (s) \_\_\_\_\_

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Thank you very much for taking time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this form. We look forward to seeing you again soon!

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**Patient Signature**

Date \_\_\_\_\_