NOTICE OF PRIVACY PRACTICES

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

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP).
This Notice describes how your medical information may be used and disclosed by us.
It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.
If you have any questions about this Notice, the name and phone number or our contact person is listed on this page.

Effective Date of this Notice	**October 1, 2003**
Phone Number	**(559) 435-3113**

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES*.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way."

_____

Patient or Representative Name (Please Print)

_____ _____

Patient or Representative Signature **Date**

☐ Patient refused to sign ☐ Patient was unable to sign because _____

Financial Interest Disclosure

Under California law, I (Dr. Mirelez) am required to inform you, that I have a financial interest in **Dental Imaging Solutions,** to which I may refer you for services. There may be other organizations from which you may obtain these services. Should I decide to refer you to **Dental Imaging Solutions,** you should know that there may be alternative locations to acquire similar requested services.

Acknowledgement of Publicity Materials

I authorize the taking of clinical photographs and videos and their use for scientific, educational and marketing purposes both in publications and presentations. I understand that photographs and video may be taken of me for educational and marketing purposes. I hold Mirelez Wellness Dental harmless for any liability resulting from this production. I waive my rights to any royalties, fees and to inspect the finished production as well as advertising materials in conjunction with these photographs.

_____

Signature **Date**

J. ART MIRELEZ JR., DDS, FICOI, FAGD
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