ENDODONTIC EXCELLENCE
WHERE CARING IS OUR SPECIALTY

International Tower at Reston Heights
11800 Sunrise Valley Drive, Suite #250
Reston, Virginia 20191

703-429-9926
info@endoreston.com
www.endoreston.com

NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Introduction:
This document explains how your health information may be used and disclosed, and outlines your rights regarding your protected health information (PHI). It also provides consent for the use of PHI for routine purposes.

SECTION 1: NOTICE OF PRIVACY PRACTICES (NPP)

Our Legal Duty
We are required by law to maintain the privacy of your health information and provide you with this Notice. It describes how we use and disclose your information and your rights regarding that information. We must comply with the practices described in this Notice while it is in effect. Updates will be available upon request.

Uses and Disclosures
We may use or disclose your PHI for:

- **Treatment:** Sharing information with other healthcare providers involved in your care.
- **Payment:** Processing claims and obtaining payment for services.
- **Healthcare Operations:** Activities such as quality assessments, staff training, and compliance reviews.

Your Authorization:
We will not use or disclose your information for purposes beyond treatment, payment, or operations without your written authorization. You may revoke this authorization at any time in writing. Revocations will not affect disclosures made prior to receipt of the revocation.

Your Rights:
You have the right to:

- Access and request copies of your records (fees may apply).
- Request restrictions on certain disclosures (subject to approval).
- Request alternative means of communication (e.g., home vs. work address).
- Amend information in your records.
- Request an accounting of disclosures.
- File a complaint without retaliation if you feel your rights have been violated.

Contact Information:
For questions or to request copies of this Notice, contact:

- **Contact Officer:** Dr. Wonhee Lee
- **Phone:** 703-429-9926
- **Email:** info@endoreston.com

SECTION 2: CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent:
By signing this section, you consent to the use and disclosure of your PHI for treatment, payment, and healthcare operations.

Revocation:
You may revoke this consent at any time by providing written notice. Revocation does not affect actions taken prior to receipt of your notice and may impact your ability to receive treatment.

SECTION 3: CONSENT AND AUTHORIZATION SIGNATURES

Patient Acknowledgment:
I have read and understand the Notice of Privacy Practices and the Consent for Use and Disclosure of Health Information. I acknowledge my rights and provide consent as outlined above.

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Patient Name: _____
Signature of Patient or Legal Guardian: _____
Date: _____
Preferred Communication Methods: (Check all that apply)

- Home Phone: ☐ OK to leave message ☐ Call-back only
- Mobile Phone: ☐ OK to leave voicemail ☐ Text message ☐ Call-back only
- Email: ☐ Yes ☐ No

Authorized Individuals for Information Sharing:

- Spouse: ☐ Yes ☐ No
- Parent: ☐ Yes ☐ No
- Child: ☐ Yes ☐ No
- Other: _____
- None: ☐