

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)

Ochave Dental (Frederick P. Ochave, DMD, PLLC)
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Virginia Beach, VA 23456 757-497-1618
ATT: HIPAA Compliance Officer

Ochave Dental is committed to protecting the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your PHI, to provide you with this Notice of Privacy Practices, and to follow the terms of this Notice currently in effect. This Notice explains how we may use and disclose your PHI, your rights regarding your PHI, our legal duties, and whom to contact for additional information or to file a complaint.

How We May Use Your Information

- We may use and disclose your PHI to provide, coordinate, or manage your dental care. This includes sharing information with other health care providers, specialists, laboratories, pharmacies, or other entities involved in your treatment.
- We may use and disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, processing claims, determining eligibility or coverage, and collecting copayments or balances.
- We may use and disclose your PHI for activities necessary to operate our practice. These activities may include quality assessment and improvement, staff training, accreditation, licensing, compliance reviews, audits, business planning, and administrative functions.
- To comply with federal, state, or local laws For public health activities (e.g., disease prevention, reporting adverse events) For health oversight activities (e.g., audits, investigations, inspections)
- In response to court orders, subpoenas, or lawful processes
- For law enforcement purposes, as required by law
- To avert a serious threat to health or safety
- For workers' compensation or similar programs
- We will never share any substance abuse treatment records without your written permission, unless required by law. Your record cannot be used in legal proceedings against you without your consent.

Your Choices

We will obtain your written authorization before using or disclosing your PHI for purposes not described in this Notice, including: Marketing activities. You may revoke an authorization at any time in writing, except to the extent that action has already been taken in reliance on it.

Your Rights Regarding Your PHI

- You have the right to inspect and obtain a copy of your PHI, with limited exceptions. We will respond within the timeframe required by law and may charge a reasonable, cost-based fee.

Effective Date: February 16, 2026

- If you believe your PHI is incorrect or incomplete, you may request an amendment. We may deny your request under certain circumstances, in which case you may submit a written statement of disagreement.
- You may request restrictions on how we use or disclose your PHI for treatment, payment, or health care operations. We are not required to agree to all requests, except as required by law.
- You may request that we communicate with you in a specific manner or at a specific location (for example, at an alternate phone number or address).
- You may request a list of certain disclosures of your PHI made by us, as permitted by law.
- You have the right to receive a paper copy of this Notice upon request.

Our Legal Duties

We are required by law to: maintain the privacy and security of your PHI; provide you with this Notice explaining our legal duties and privacy practices; and to notify you following a breach of unsecured PHI, as required by law

Questions or Complaints

Should you have any questions about this notice, please contact our practice. If you believe your privacy rights have been violated, you may file a complaint with: our practice, using the contact information listed above, or The U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time. Any changes will apply to all PHI we maintain. Updated Notices will be available upon request and posted in our office and on our website, if applicable.

I hereby acknowledge that I have read and fully understand the contents of this notice, and I have been given the opportunity to ask any and all questions.

Name _____ Circle one:
Self Parent/Guardian

Signature _____ Date _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this document, but was unable to do so.

Staff signature _____ Date _____

Reason given: