Privacy Policy & HIPAA Consent

At **Lake Success Dental Care**, we respect your privacy and follow federal HIPAA regulations to protect your health information. Below is a summary of how we use and share your information and your rights under HIPAA.

The full Notice of Privacy Practices is available anytime at: https://lsdentalcare.com/hipaa

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Your Rights
You have the right to:

- Access or request a copy of your dental or medical record.
- Ask us to correct information you believe is inaccurate or incomplete.
- Request confidential communication or limit what we share.
- Receive a list of certain disclosures we've made.
- Choose someone to act for you (such as a legal guardian).
- File a complaint without fear of retaliation if you believe your privacy rights have been violated.

How We Use and Share Information
We may use or share your information to:

- **Treat you:** Coordinate and manage your dental care.
- **Bill for services:** Process insurance claims and collect payment.
- **Run our practice:** Improve care quality and manage daily operations.
  We may also share information when required by law or for public health, safety, or legal reasons (such as preventing disease, reporting abuse, or responding to court orders).

Our Responsibilities

- We are required by law to protect your health information.
- We will notify you if a data breach occurs that may compromise your privacy.
- We will not use or share your information other than as described here or as authorized by you in writing.
- You can always request a paper or electronic copy of the full Notice of Privacy Practices.

Acknowledgment & Consent
I acknowledge that I have received or been offered access to **Lake Success Dental Care's Notice of Privacy Practices**.

I understand and agree that my health information may be used or disclosed for treatment, payment, and healthcare operations as described above.

I understand that disclosures will follow HIPAA's minimum necessary standard, and that I may revoke this consent in writing at any time, except to the extent action has already been taken.
A copy of this signed acknowledgment is as valid as the original.

By signing below, I consent to the use and disclosure of my protected health information as described.