



White Plains Dental, P.L.L.C.
19 S Broadway, White Plains, NY 10601
Tel: 914-948-0088

NOTICE OF PRIVACY PRACTICES Effective Date: February 16, 2026

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

White Plains Dental P.L.L.C. is committed to protecting your health information. This Notice applies to all protected health information (PHI) that we create or receive.

Our Legal Duties

We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice that is currently in effect
- Notify you in the event of a breach of your unsecured PHI

We may change the terms of this Notice at any time. Any changes will apply to all PHI we maintain. The revised Notice will be posted in our office and available upon request.

What is Protected Health Information (PHI)?

PHI is any information about your health, dental care, or payment for care that can identify you. This includes dental history, X-rays, treatment notes, and billing information.

Substance Use Disorder (SUD) Records – 42 CFR Part 2

If we receive records relating to substance use disorder (SUD) treatment from a federally assisted program, these records have additional federal protections under 42 CFR Part 2. We generally need your specific written consent to use or disclose these records for most purposes, including treatment, payment, or health care operations. We will follow both HIPAA and these stricter Part 2 requirements.

How We May Use and Disclose Your PHI (Without Your Authorization)

We may use or disclose your PHI for the following purposes:

- **Treatment:** To provide, coordinate, or manage your dental care (for example, with dental labs, specialists, or other health care providers).
- **Payment:** To bill and collect payment for services we provide (for example, with your insurance company or third-party payers).
- **Health Care Operations:** To run and improve our practice (for example, quality improvement, staff training, and business planning).

Other Permitted or Required Uses and Disclosures include:

- As required by law (including New York State requirements)
- Public health and safety activities

- Judicial and administrative proceedings
- Law enforcement (as permitted or required)
- Workers' compensation claims
- Business associates who perform services for us (they are required to protect your PHI)
- Limited research purposes
- Coroners, medical examiners, or organ/tissue donation organizations
- Emergencies or situations involving imminent threat to health or safety

We will obtain your written authorization for any other uses or disclosures, such as marketing or the sale of your PHI. You may revoke an authorization in writing at any time (except for actions already taken in reliance on it).

Your Rights

You have the following rights regarding your PHI:

- Request restrictions on certain uses and disclosures of your PHI (we are required to honor restrictions when you pay out-of-pocket in full for a service)
- Request confidential communications (for example, to a different address or phone number)
- Inspect and obtain a copy of your PHI (we may charge a reasonable fee for copies)
- Request an amendment to your PHI if you believe it is incorrect or incomplete
- Receive an accounting of certain disclosures of your PHI
- Obtain a paper copy of this Notice at any time
- File a complaint if you believe your privacy rights have been violated (no retaliation)

To exercise any of these rights, please submit a written request to our Privacy Officer.

Privacy Officer White Plains Dental P.L.L.C 19 S Broadway, White Plains NY, 10601

Phone: (646) 721-1508 Email: larisa@whiteplainsnydental.com

You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights: 1-800-368-1019 www.hhs.gov/ocr

BACK SIDE (Print on reverse side – Acknowledgment Form)

White Plains Dental P.L.L.C ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES Effective February 16, 2026

I acknowledge that I have received a copy of Riverdale Dental P.C.'s Notice of Privacy Practices.

Patient Name (print): _____

Patient Signature: _____ Date: _____

If signed by a representative: Representative Name: _____

Relationship to Patient: _____ Date: _____

Office Use Only Patient refused to sign Patient unable to sign (reason):

_____ Staff Initials: _____ Date: _____