

Orofacial Pain Associates Notice of Privacy Practices Last Update: 04/2026

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS IT. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy and security of your health information and to provide you with this Notice of our legal duties and privacy practices. We must follow the terms of this Notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We limit uses and disclosures of your health information to the minimum necessary to accomplish the intended purpose, as required by law. We may use or disclose your health information without your written authorization for the following purposes:

Treatment: We use your health information to provide, coordinate, or manage your care. This may include sharing information with other healthcare providers or referring you to specialists.

Payment: We may use your health information to collect payment for services directly from you. Although we do not bill insurance, we may disclose relevant health information at your request, or as necessary, to support a claim you submit to your insurance company or other third-party payer for reimbursement of services you have already paid for.

Health Care Operations: We may use your information to operate and improve our practice. This includes activities such as quality assessment and improvement, staff training, licensing and credentialing, and general administrative and business functions.

Appointment Reminders and Communication: We may contact you regarding appointments, follow-up care, or other healthcare-related matters. Communication may occur by phone, voicemail, text message, email, or mail.

As Required by Law: We will disclose your health information when required by federal or Colorado law, including in response to court orders, subpoenas, public health reporting requirements, or reports of abuse or neglect.

Public Safety and Government Functions: We may disclose your information for law enforcement purposes, national security activities, or to military or correctional institutions when applicable.

De-Identified Information: We may use or disclose information that does not identify you for research, education, or operational purposes.

USES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not use or disclose your health information without your written authorization for purposes not described in this Notice. This includes sharing information with family members, friends, or others involved in your care, as well as most uses and disclosures for marketing purposes and any sale of your health information. You may revoke your authorization in writing at any time. Your revocation will not affect any use or disclosure already made in reliance on your authorization.

SPECIAL PROTECTION: SUBSTANCE USE DISORDER (SUD) RECORDS

If applicable, records protected under 42 CFR Part 2 are subject to additional confidentiality protections. These records require your specific written consent for disclosure and generally may not be used in legal proceedings without a court order.

ADDITIONAL PRIVACY PRACTICES

AI-Assisted Documentation (Ambient Listening Technology): We may use secure, HIPAA-compliant technology to assist with documenting your visit, including tools that transcribe conversations or help generate clinical notes. All information is encrypted in transit and at rest and is used solely for treatment, payment, and health care operations. No recordings or data are used for purposes outside your care without your written authorization. These technologies function as tools to assist your provider and do not replace clinical judgment.

Electronic Communication and Patient Portal: If you choose to communicate with us electronically, including by email or through our website, you should be aware that standard electronic communication methods may not be fully secure and may carry some risk of unauthorized access. By choosing to communicate electronically, you acknowledge and accept these risks. We encourage use of our secure patient portal whenever possible.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to inspect or obtain a copy of your health information. Requests must be made in writing, and reasonable, cost-based fees may apply.

You have the right to request that we amend your health information if you believe it is incorrect or incomplete. Requests must be submitted in writing and must include a reason supporting the requested amendment.

You have the right to receive an accounting of certain disclosures of your health information made within the past six years, excluding disclosures made for treatment, payment, or health care operations.

You have the right to request restrictions on how your health information is used or disclosed. While we are not required to agree to all requests, we will honor any restrictions to which we agree.

You have the right to request that we communicate with you using alternative methods or at alternative locations. These requests must be made in writing.

You have the right to obtain a paper copy of this Notice at any time, even if you previously received it electronically.

BREACH NOTIFICATION

If a breach occurs that may compromise the privacy or security of your health information, we will notify you as required by law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint directly with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Orofacial Pain Associates 2575 Montebello Dr W, Ste 202 Colorado Springs, CO 80918 Phone: 719-260-0600 Fax: 719-264-9235 Email : frontdesk@ofpcos.com	Office for Civil Rights, U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Phone: 1-877-696-6775 www.hhs.gov/ocr/privacy/hipaa/complaints/
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OUR RESPONSIBILITIES

We are required to maintain the privacy and security of your health information, provide you with this Notice, notify you in the event of a breach, and follow the terms currently in effect. We will not use or disclose your health information without your authorization except as described in this Notice. We reserve the right to change this Notice at any time, and updated versions will be available upon request and on our website.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered and/or received a copy of the Notice of Privacy Practices for Orofacial Pain Associates. This Notice describes how my health information may be used and disclosed and outlines my rights regarding my health information.

I understand that I have the right to review this Notice in full and to ask questions about its contents. I have been given the opportunity to ask questions and receive answers to my satisfaction.

I understand that I may request a paper or electronic copy of the Notice at any time.

Patient Information

Patient Name: _____

Date of Birth: _____

Signature

Signature of Patient or Personal Representative: _____

Date: _____

If signed by Personal Representative, describe authority: _____

FOR OFFICE USE ONLY

We made a good faith effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices.

Patient received and signed acknowledgment

Patient refused to sign

Unable to obtain acknowledgment (reason): _____

Staff Name: _____

Staff Signature: _____

Date: _____