Central Texas Orthodontics

Dr. Brian St. Louis, D.D.S, M.S
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Notice of Privacy Practices

Our Legal Duty:

Our office is required by law to maintain the privacy of your health information, to give you notice about how we do this and what your rights are.

How we use your health information:

We use your health information for treatment, payment, and healthcare operations.

This means- We may discuss your health information with another doctor or healthcare worker involved in your treatment. We may disclose your PHI which can be used for work/school excuses and discussion of PHI with family, a friend or other persons in case of a language barrier. We may use this information to obtain payment for your treatment and third parties such as insurance companies. We may also use this information for our internal operations such as training and quality assessment and to contact you about appointments using phone, mail, or email.

You have the right to decide who else, by specific signed authorization, has access to your health information such as family members, employers, marketing companies, or other entities not directly related to our office or your treatment.

We must disclose your health information when required to do so by law or if we believe your health and/or safety or the health and/or safety of others is threatened.

Your Rights:

You may request in writing a copy of your health information. We may charge a reasonable fee for this service.

Upon request, a more detailed and lengthy explanation of our policies is available.

Questions and complaints:

If you have any issues concerning the privacy of your health information, you may direct your complaints to the contact person listed below. You may also submit a written complaint to the US Dept. of Health and Human Services.

Contact: Brian St. Louis D.D.S., M.S.
Phone number: 512-292-1910
Email: info@ctorthodontics.com

Thank you for helping our office comply with the federal law on health information privacy policies.

Acknowledgement of receipt of notice of privacy practices:

Date: _____

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name: _____ Signature: _____
(patient name if different from above)