

Waterplace Dental

Effective Date: February 16, 2026

NOTICE OF PRIVACY PRACTICES

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

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your provider.

This **notice describes** how your **medical information may be used** and disclosed and how you can **access** this information. **Please review it carefully.**

How We May Use and Disclose Your Information

We **may use** and disclose **health information** about **you** without your **permission for the** following **reasons**:

1. **For Treatment:** To coordinate or manage **your care with other providers or facilities.**
2. **For Payment:** To obtain reimbursement from **insurance for services** provided.
3. **For Healthcare Operations:** To **improve our services, manage our practice, train staff, and perform audits.**
4. **For Legal Requirements:** When required by **federal, state, or local law.**
5. **To Prevent Serious Threats:** To protect your **health and safety or the health and safety of others.**
6. **For Public Health and Safety:** Including **disease prevention, abuse reporting, and FDA oversight.**
7. **For Research:** When **reviewed and approved under a special process.**
8. **For Workers' Compensation and Law Enforcement:** When **required** under these **programs.**
9. **With Family or Friends:** If **involved** in your **care and based on your preference or best interest.**

We will **only share the minimum necessary** information **needed** for

each purpose.

We will not **use** or **disclose your health** information for **marketing**, **sale**, or **fundraising** without your written authorization. **You may revoke this authorization at any time** in writing.

Special Protections: Substance Use Disorder (SUD) Records

If **your** medical record **includes** information **related to substance use** disorder treatment protected under federal law (**42 CFR Part 2**), that information **has** additional **privacy** protections:

We **will** not **disclose** it without your written **consent** unless required by **law**. **It may** not **be** used in court **or legal** proceedings without a **special** court **order**.

You
 may revoke
 your **consent at any time**.

Any re-disclosure of **this information** by others **may** no longer be protected.

You have the right to opt out of any fundraising communications.

Special Protections Under Oregon

Law

Oregon law **provides** additional **privacy** protections **for certain types** of **health** information. **These laws may limit how** we use or **disclose this** information, **even when** disclosure would **otherwise** be permitted under **federal law (HIPAA)**.

This includes:

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HIV/AIDS and HIV testing information (ORS 433.045), which **may** not be **disclosed** without **your specific** written authorization **except** as permitted by **law**.

Mental health treatment information (ORS 179.505-179.509), which **may** have additional restrictions **on use** and disclosure.

Genetic information (ORS 192.531–192.549), which is subject to **special confidentiality** protections.

Substance Use Disorder treatment records protected under **federal law** (42 CFR Part 2), **as** described above.

Your Rights

You **have the right to**:

Access: Ask to **see** or **get a copy of your health** and billing records.

Amend: Ask us to correct your **records** if you think **they're incorrect**.

Request Restrictions: Ask us not to **use** or **share certain** information. We **are** not required to **agree** but **will consider** your **request**.

Request Confidential Communications: Ask us to contact you **in a specific way** (e.g., only **at work**, no **voicemail**).

Accounting of Disclosures: Ask for a list of when **we shared** your information for reasons **other** than **treatment, payment, or healthcare** operations.

Get a Copy of This Notice: You can request a **paper copy** at any time.

Be Notified of a Breach: You **will** be notified if a **breach occurs** that may have **compromised** your **protected health** information.

To exercise any *of* these rights, **contact** our **Privacy Officer** using the **details** at the bottom of **this page**.

Our Responsibilities

We **are** required **by law** to:

Keep your **health** information **private**.

Provide **you** with this Notice.

Follow **the terms** of **this** Notice.

Notify you **if a breach** of your protected information occurs.

We may change our **privacy practices** and **update** this Notice. **If we do**, the **new terms** will apply to **all health** information we **maintain**. **We will** post the updated Notice in our office **and** on our **website**, **and make copies available** upon request.

Complaints and Questions

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

Contact for **complaints** or **more information**:

Privacy Officer

**Waterplace
Dental**

500 **Liberty** St SE, Suite 300 **Salem, Oregon 97301** (503) 581-2454

We are committed to **earning** and maintaining your **trust** by protecting your **health** information with **care** and **respect**.

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