

PATIENT PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we will provide the minimum amount of necessary information to only those whom we feel are in need of your health care information regarding treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may at times have indirect treatment relationships regarding you as a patient, such as laboratories that only interact with doctors and not the patient directly. At those times we may have to disclose personal health information for the purpose treatment, payment and/or health care operations. These entities are most often not required to obtain direct patient consent.

You may refuse to consent to the use or disclosure of your personal health information in writing. Therefore, under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). At anytime in the future you may request in writing to refuse all or part of this document that you are signing today. You may not revoke previous actions taken, which have relied on this, or an earlier signed consent.

If you have any objections to this form, please ask to speak to our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions or revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our valued patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "privacy rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As a part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

If your record is requested to leave or be transferred from our office, your signature is required below to release this record and all the information pertaining to your treatment to the person or persons requesting such documents.

Signature: _____

Date: _____