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**Privacy Assurance Notification and
Patient Consent Form**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. This Act gives you, the patient the right to understand and control how your health information is used.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information.

Only when it is appropriate and necessary will we provide the minimum necessary information to those we feel are in need of your health care information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We also want you to know that we support your full access to your personal medical records. You may refuse to consent to disclose your personal health information, but this must be done in writing. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal history information. You may not revoke actions that have already been taken which relied on this or previously signed consent. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your personal health information.

Print Name: _____ **Date:** _____

Signature: _____