HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years.

What this is all about: There are rules about who may see or know your Protected Health Information (PHI). These restrictions do not impede the normal interchange of information necessary to provide you with dental care. HIPAA defines certain rights and protections for you as the patient. We balance these rights with our goal of providing you with quality, courteous professional care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories and health insurance payers as is necessary and appropriate for your care. Patient files are stored in file cabinets and password protected databases. In the normal course of providing care records may be left temporarily in administrative areas and treatment rooms. Your records are not available to persons other than office staff. You agree to these normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. As a courtesy, we remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or other means requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

4. You agree to bring any concerns regarding privacy to the attention of the office manager or the doctor.

5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

6. We agree to provide patients with access to their records in accordance with state and federal laws.

7. We may change, add, delete or modify any of these provisions to better serve your needs or the needs of the practice.

8. You may request particular restrictions on the use of your PHI.

Please Print Legibly

I, _____ Date_____

Please indicate relationship: **self _____ Parent or Guardian _____ Patient Name_____**

do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature:_____