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Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the HIPPA of 1996 (Health Insurance Portability and Accountability Act).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

_____ Patient gives office permission to use any contact written on patient information form
Please check any that you DO NOT want the office to call, we will be using the numbers/emails you have updated, on your Account information. All information is subject to availability to verify and validate.
__ work cell __work phone __work email __work fax __mail to work __ mail to work
__ personal cell __ home phone __ home email __home fax __mail to home
__emergency contact __ interpreter contact __ ANY OF THE ABOVE

List names of who can have access to your dental/medical chart information: circle Type
State what part of your chart: Financial/Treatment Health history, is allowed to be disclosed or copied
_____ FULL access/Partial access _____

_____ FULL access/Partial access _____

__ Patient gives office permission to forward any verified contact information and PHI to patient's specialist. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any sources other than your Healthcare Providers, will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS, is the only means of communication with those involved in patients' case, which is considered HIPPA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: _____
Print Legal Guardian's Name: _____ **Date:** _____
Signature of Patient or Legal Guardian: _____ **Date:** _____

___ Patient refused to sign HIPPA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer
Office Staff Signature _____ Printed Name: _____ Date: _____