DENTAL HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

Patient information will be kept confidential except as is 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, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, and other documents or information.

It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, or by any means convenient for the practice and/or as 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.

The practice utilizes a number of vendors in the conduct of business. These vendors may have access to the patient history information but must agree to abide by the confidentiality rules of HIPAA.

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.

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

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

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

We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

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

Patient Information		
First Name	**Last Name**	**Date of Birth**

Signature Date: Signature: