Palos Dental Center

12721 S. Harlem Avenue

Palos Heights, IL 60463

HIPPA Acknowledgment

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other identifiable health information used or disclosed by us in any from, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information. We may use and disclose your medical \ dental records only for each of the following purposes: treatment, payment, and health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be working with a specialist such as an oral surgeon. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim to your insurance company for payment. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be sending financial information to an accountant for auditing and tax purposes. We may also create and distribute de-identified health information by removing all references to individually identifiable information such as name, phone numbers, etc. We may contact you to provide appointments or information about treatment options or other health-related benefits and services that may interest you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a request to this office: The right to request restrictions on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. However, if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly Obtain payment from third-party payers Conduct normal healthcare operations such as quality assessments and dental certifications I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the above address to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____

Patient/Parent/Guardian's Signature: _____

Date: _____