Palm Dental Group

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HIPPA INFORMATION FORM
(Privacy Protection)

Patient Name: _____ _____ _____ ___ _____
Last First MI Preferred Name

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides safeguards to protect your privacy. These safeguards include restrictions on whom may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPPA provides certain rights and protection to you as the patient. We must balance these needs with our goal of providing you with quality service and care. Additional information is available by calling the U.S. Department of Health and Human Services or at: http://www.hhs.gov.

For this reason, our practice has adopted the following policies:

1. Patient information will be kept confidential except as is needed to provide treatment 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, as is necessary and appropriate for your care. Patient files may be stored in open file racks but will not contain any coding which identifies a patients' 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 in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agrees to abide by the confidentiality rules of HIPAA.

4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performances of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods of normal value.

7. The practice agrees to provide the patient with access to their records in accordance with the law.

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

9. You have the right to request restrictions in the use of your Protected Health Information and to request changes in certain policies used within the office concerning you PHI. However, the practice is under no obligation to alter internal policies to confirm your request.

HIPAA CONSENT & ACKNOWLEDGMENT FORM

I,.....(Parent or Guardian) .do hereby Consent and Acknowledge my agreement to the terms set forth in the " HIPAA INFORMATION FORM " and any subsequent changes in office policy understand that this consent and acknowledgment shall remain in force definitely

Signature _____ **Date** _____

Response Date: ___/___/_____