Patient HIPAA Compliance Consent Form

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that the doctor and all staff member continually undergo training so that we may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule".

The Department of Health and Human Services has established a "Privacy Rule" to help insure that your personal health information is protected from unnecessary distribution. The Privacy rule has also been created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations. We strive to achieve the very highest standards of ethics, integrity, and quality in performing services for our patients. As our patient, we want you to know that we respect the privacy of your personal dental records, and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. None of your private information will be released to anyone but you without your expressed written consent.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also want you to know that we support your full access to your personal dental records. Other business that we deal with may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients). In cases such as these, we may have to disclose some personal health information for purposes of treatment, health care operations or payment. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information. Should you refuse to disclose your personal health information to us, we have the right to refuse to treat you under this law. Should you disclose your information to us, but refuse to allow us to disclose it to your insurance company; you will be responsible for the full balance on your account at the time of service, instead of the customary 30 day grace Period that we allow for 3rd parties to pay.

I, _____ **DO** hereby consent for **Henrickson Dental** to release the minimum amount of my personal health information necessary for treatment, health care operations or payment to any necessary entity, business or person. I understand that no information will be released that is not absolutely necessary to the situation.

OR — ***Sign only one***

I, _____ **DO NOT** consent for any of my personal health information to be released by **Henrickson Dental** to any entity, business, or person other than myself, unless I specifically, in writing, authorize this release of information each and every time it is needed. I understand that this decision means that I am responsible for all balances on my account at the time of service, and that I am responsible for filing my own insurance claims for reimbursement.

Patient Name _____ Date _____

Signature of Patient OR Parent/Guardian _____