Art of Dentistry

HIPAA Consent

THIS NOTICE DESCRIBES TO WHOM MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records. Our benefits office (or other third party designated by our office) may sometimes need to disclose medical information or payment information protected by HIPAA in relation to our group health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us if you are in the hospital to determine whether a particular procedure is covered under our group health plan or may need assistance filing a claim for medical services. Under HIPAA, unless you specifically object we are allowed to use our professional judgment in deciding whether to discuss you medical and payment information with you family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your medical or payment information under our group health plans.

☐ You may communicate with the following individuals relating to my medical or payment information:

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

☐ Please do not discuss my medical or payment information with the following individuals:

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

☐ Please do not discuss my medical or payment information with anyone.

___________________________ ___________________________

Signature of Patient or Guardian Date

___________________________ ___________________________

Print Name Relationship to Patient

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, _______________________________________, hereby acknowledge that I have been given the opportunity to review a copy of **Art of Dentistry's** *HIPAA Notice of Privacy Practices*.

I understand that **Art of Dentistry's** *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of **Art of Dentistry's** revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about **Art of Dentistry's** *HIPAA Notice of Privacy Practices*, I may contact **Zonia Lopez at 423-362-7962**.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Art of Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Art of Dentistry's** privacy policies and procedures.

___________________________ ___________________________

Signature of Patient or Guardian Date

___________________________ ___________________________

Print Name Relationship to Patient