BROOKWOOD
DENTAL CARE

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (“HIPPA”) IS A FEDERAL PROGRAM THAT REQUIRES THAT ALL MEDICAL RECORDS AND OTHER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION USED OR DISCLOSED BY US IN ANY FORM, 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 USE AND DISCLOSE YOUR HEALTH INFORMATION.

WE MAY USE AND DISCLOSE YOUR MEDICAL RECORDS ONLY FOR EACH OF THE FOLLOWING PURPOSES: TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

- TREATMENT MEANS PROVIDING, COORDINATING, OR MANAGING HEALTH CARE AND RELATED SERVICE BY ONE OR MORE HEALTH CARE PROVIDERS. AN EXAMPLE OF THIS WOULD INCLUDE TEETH CLEANING SERVICES.
- PAYMENT MEANS SUCH ACTIVITIES AS OBTAINING REIMBURSEMENT FOR SERVICE CONFIRMING COVERAGE, BILLING OR COLLECTION ACTIVITIES, AND UTILIZATION REVIEW. AN EXAMPLE OF THIS WOULD BE SENDING A BILL FOR YOUR VISIT 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 FUNCTION, COST MANAGEMENT ANALYSIS, AND CUSTOMER SERVICE. AN EXAMPLE WOULD BE AN INTERNAL QUALITY ASSESSMENT REVIEW.

WE ALSO MAY CREATE AND DISTRIBUTE DE-IDENTIFIED HEALTH INFORMATION BY REMOVING ALL REFERENCES TO INDIVIDUALLY IDENTIFIABLE INFORMATION.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT YOUR TREATMENT ALTERNATIVE OF OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

ANY OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOU WRITTEN AUTHORIZATION IN WRITING AND WE ARE REQUIRED TO HONOR AND ABIDE BY THAT WRITTEN REQUEST, EXPECT TO THE EXTENT THAT WE HAVE ALREADY TAKEN
ACTIONS RELYING ON YOUR AUTHORIZATION.

YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION, WHICH YOU CAN EXERCISE BY PRESENTING WRITTEN REQUEST TO THE PRIVACY OFFICER.

- THE RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES OF PROTECTED HEALTH INFORMATION, INCLUDING THOSE RELATED TO DISCLOSURES TO A FAMILY MEMBER, OTHER RELATIVES, CLOSE PERSONAL FRIENDS, OR ANY OTHER PERSON IDENTIFIED BY YOU. WE ARE, HOWEVER, NOT REQUIRED TO AGREE TO REQUESTED RESTRICTION. IF WE DO AGREE TO A RESTRICTION, WE MUST ABIDE BY IT UNLESS YOU AGREE IN WRITING TO REMOVE IT.
- THE RIGHT TO REASONABLE REQUESTS TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION FROM US BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS.
- THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION
- THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OR PROTECTED HEALTH INFORMATION.
- THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US UPON REQUEST.
  WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF OUR PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU

WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

THIS NOTICE IS EFFECTIVE AS OF MARCH 19TH, 2003 AND WE ARE REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE PRIVACY PRACTICES CURRENTLY IN EFFECT. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

WE WILL POST AND YOU MAY REQUEST A WRITTEN COPY OF A REVISED NOTICE OF PRIVACY PRACTICES FROM THIS OFFICE.

YOU HAVE RECOURSE IF YOU FEEL THAT OUR PRIVACY PROTECTIONS HAVE BEEN VIOLATED. YOU HAVE THE RIGHT TO FILE WRITTEN COMPLAINT WITH OUR OFFICE, OR WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, ABOUT VIOLATIONS OF THE PROVISIONS OF THIS NOTICE OR THE POLICIES AND PROCEDURES OF OUR OFFICE. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT:

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF CIVIL RIGHTS
200 INDEPENDENCE AVE, S.W., WASHINGTON D.C., 20201
(202)629-0257 TOLL FREE (877) 696-6775.

I understand the above information and agree with its contents, and this will serve as my consent.

Signature* Date*

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