FAMILY DENTISTRY EVERY smile + ORTHODONTICS

HIPAA ACKNOWLEGEMENT FORM

Health Insurance Portability and Accountability Act

Protecting Your Confidential Health Information is Important to Us

This notice describes how health information about you may be used and how information can be obtained. Please review carefully. Feel free to ask us any questions.

Our Promise:

It is our desire to communicate to you that we are taking the Federal HIPAA (Health Insurance Portability and Accountability Act) laws, which protect the confidentiality of your health information, seriously. Your personal health information will never be made available to others outside our office, unless it is accordance with the legally authorized provisions below:

- To Provide Treatment
- To Obtain Payment
- To Conduct Health Care Operations
- In Patient Reminders
- Family, Friends, and Caregivers (only if authorized by patient)
- To Law Enforcement, Public Health Authorities, or the Court System (as allowed by law)

I have received a notice of the privacy acts and have had an opportunity to review it.

Patient Name (printed) ____

Patient Signature____Date_________________

I give the following people access to my information on an as needed basis:

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Patient Signature____Date_________________