BETHESDA DENTAL GROUP

HIPAA PATIENT ACKNOWLEDGEMENTOF PRIVACY PRACTICES FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure the personal health care information is protected for privacy. The Privacy Rule was also 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.

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. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, In order to provide health care that is in your best interest.

We also want you to know that we support our full access to your personal dental records as provided by the Virginia Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. 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, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuseto disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer at 540-465-3399

HIPAA PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICESSIGNATURE PAGE

I have read and received a copy of the HIPAA patient acknowledgement information and I understand that my personal health information will be protected and shared with only those I authorized with a signed consent form.

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I also have the right to review Strasburg Family Dentistry's privacy notice, to request restrictions and revoke consent, in writing, after I have reviewed this notice.

I further understand that my information could be used to obtain payment from third-party payers for my health care services.

It may also be used under normal health care operations, such as quality assessment and improvement activities.

I have been informed of Strasburg Family Dentistry's privacy practices and have received a more complete copy containing information about my personal health information (PHI). I understand that Strasburg Family Dentistry has the right to change their practices and that I may contact the office to receive a current copy of their privacy practices.

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Print Patient / Parent / Guardian's Name

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Signature

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Witness Signature

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Date