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HIPAA Policy
Health Insurance Portability and Accountability Act

The privacy of your medical information is important to us. We understand that your health care information is personal and we are committed to protecting it. We create a record of the care and services you received at our office. We need this record to provide you with quality care and to comply with certain legal requirements.
From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care provider in order to provide you with the best health care options. We may also need to disclose information regarding your treatment to your insurance company to assist with payment on your account.
By signing below, I acknowledge that I understand the policies in place to keep my information private according to the Notice of Privacy Practices.

_____
Name of patient

_____ _____
Patient/Parent signature **Relationship to patient**

Patient consent

I further authorize this office to release information regarding my care to the following:

( ) Spouse Name:_____
( ) Parent Name:_____
( ) Children Name:_____ ( ) Other: _____
( ) Account Payer _____ ( ) Insurance Company_____

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I choose to not sign this HIPAA policy and, therefore, agree to pay in full and accept responsibility for billing insurance and coordinating any dental care needed outside of this office.

Name: _____ Date: _____