Dulac Dental
of Springfield

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# Notice of Privacy Practices (HIPPA)

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 payer (e.g. my insurance company)
- The day-to-day healthcare operations of the 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 more complete description of the uses and disclosures of my protected health information, and my rights under **HIPAA**. I understand that the terms of this notice may change 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.

☐ I further allow my dental information to be shared with the following person:

**Name**: ______________________________

**Relationship**: __________________________

☐ I **DO NOT** allow my information to be shared with anyone else.

If you would like us to discuss or answer questions about your treatment or bill to your spouse, mother or father, or son or daughter (if over 18 years of age); that person needs to be indicated above or we need to have a copy of a medical power of attorney on file.

______________________ ______________________ _____/_____/_____

Print Name | Signature | Date