HIPAA

Health Insurance Portability and Accountability Act

PATIENT NAME:

I understand that as a part of my oral health, this office originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as follows:

- ➢ A basis for planning my care and treatment.
- ➢ A means of communication among the health professionals who may contribute to my oral health.
- ➢ A source of information for applying my diagnosis and surgical information to my financial statements.
- ➢ A means by which a third-party payer can verify that services were provided.
- ➢ A tool for routing healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

- ❑ Read and approve

Signature of patient/guardian ***Date***