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SACHDEV FAMILY ORTHODONTICS

HIPAA CONSENT FORM

I consent to the use or disclose of my protected health information (PHI) by Sachdev Family Orthodontics PC for the purpose of treatment, payment and health care operations.* I have received a copy of the Notice of Privacy Practices and understand I have a right to review prior to signing this document.

I UNDERSTAND:

- Service to me may be conditioned upon my consent as evidenced by my signature on this document.
- I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or health care operations of the practice. Sachdev Family Orthodontics PC is not required to agree to the restrictions that I may request.
- However, if Sachdev Family Orthodontics PC agrees to a restriction that I request, the restriction is binding on Sachdev Family Orthodontics PC.
- I have the right to revoke this consent, in writing, at any time, except to the extent that Sachdev Family Orthodontics PC has taken action in reliance on this consent.
- My PHI means health information, including my demographic information, collected from me and created or received by my doctor, another health care provider, a health plan, and a health care clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me; or, there is a reasonable basis to believe the information may identify me.

THE NOTICE OF PRIVACY PRACTICES DESCRIBES:

- The types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations performed by Sachdev Family Orthodontics PC.
- My rights and the duties of Sachdev Family Orthodontics PC with respect to my PHI.

Sachdev Family Orthodontics PC reserves the right to change its privacy practices. For any information on current or revised notices, please call our office.

Patient Name (Please Print)_____

Signature of Patient/Parent_____Date_____

*Treatment includes activities performed by a dentist, dental assistant, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. Payment includes activities involved in paying your treatment, billing, insurance, etc. Health Care Options includes the necessary administrative and business functions of our office.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (i.e., to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e., the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- We will not use your health information for marketing communications without your written authorization.
- Required by Law: We may use or disclose your health information when we are required to do so by law.
- Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, ounterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;

- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of the right to change the terms of this privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's **Notice of Privacy Practices**.

Name (Please Print):

_____

First Name MI Last Name

Signature: _____Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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