ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA Form)

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

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

_____

Please print Name of patient

_____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

_____

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

_____

_____

_____

_____

HIPPA Form

Authorization to Transfer/Release Confidential Information

I, _____ authorize and request

Name of Physician:		
Address:		
City:	State:	Zip:
Phone:	Fax:	

To Release:
(Please check all that apply)

___ All Current Radiographs (Including Pano / full mouth) ___ All Perio Charting ___ Full Dental Records

Regarding_____'s care to:
Patient's Name

Name: Austin Creek Dental		
Address: 4840 N Rosepoint Way Suite A		
City: Boise	State: Idaho	Zip: 83713
Phone: 208-938-1825	Fax: 208-938-5763	
E-mail: office.austincreekdental@gmail.com		

I acknowledge that the data to be released may include material that is protected by Federal Law. My Signature below authorizes release of such information.

Signed: _____ Date: _____
(Patient or Guardian)

_____
Relationship to the Patient

Consent for purpose of Treatment, Payments and Healthcare Operations (HIPAA Form)

I consent to the use or disclosure of my protected health information by *Austin Creek Dental* for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of *Austin Creek Dental*. I understand that diagnosis or treatment of me by *Austin Creek Dental* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. *Austin Creek Dental* is not required to agree to the restrictions that I may request. However, if *Austin Creek Dental* agrees to a restriction that I request, the restriction is binding on *Austin Creek Dental* and Tim Hansen DDS.

I have the right to revoke the consent, in writing, at any time, except to the extent that Tim Hansen DDS or *Austin Creek Dental* has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information 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.

I understand I have the right to review *Austin Creek Dental's* Notice of Privacy Practices prior to signing this document. The *Austin Creek Dental's* Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that will occur in my treatment, payment of my bills or in the performance of health care operations of *Austin Creek Dental*. The Notice of Privacy Practices for *Austin Creek Dental* is also provided on a bulletin located in the front office. This Notice of Privacy Practices also describes my rights and the *Austin Creek Dental's* duties with respect to my protected health information.

Austin Creek Dental reserves the Right to change the Privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

NOTICE OF PRIVACY PRACTICES
(HIPAA Form)

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 CAREFULLLY.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

This Notice of Privacy Practices is effective on April 14, 2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to disclose your health information only for the following purposes, as defined under the Act:

- ***Treatment*** means the provision, coordination, or management of health care and related services by one or more healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a dentist referral to an orthodontist.
- ***Payment*** means obtaining reimbursement for the provision of health care: determinations of eligibility or coverage; billing; claim management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection for reimbursements (Only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- ***Health care operations*** are any activity related to cover functions in which we participate in the function of our offices, such as conducting quality assessments activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation customer service given to patients.
- ***Other disclosures and uses*** Public Health, Abuse and neglect, Workers Compensation, Food and Drug Administration, Church Ministries, Law

Enforcement, Judicial/Administrative proceedings and for Specialized Governmental Functions.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonable practicable after the delivery pf such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances.
- Pursuant to and in compliance with an authorization signed by you.
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

All other uses and disclosers will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, and prior to revocation notice.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for marketing purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions places upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a request restriction.
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations.
- You have the right to inspect and copy your protected health information.
- You have the right to amend protected health information, however, this request may be denied under certain circumstances,
- You have the right to receive an accounting of disclosure of your protected health information made by us in the six years prior to the date of the accounting request.
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or provisions of this notice of privacy have been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health & Human Services, Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA
Or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
2201 6th Avenue, Room 900
Seattle, Washington 98121
www.dhhs.gov/ocr
1-800-368-1019

OR

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4840 N Rosepoint Way Ste. A
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208-938-1825