NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

I/We , _____ parent /legal guardian I/We, _____ parent /legal guardian of (patient's name)_____authorize Innovative Pediatric Dentistry to share any information concerning appointments, treatment, exam findings, and/or finances to be shared with the following family members or others.

1._____ 2. _____

Relationship:_____ Relationship:_____

3._____ 4._____

Relationship:_____ Relationship:_____

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:

____(initial) To other health care providers (i.e. your general dentist, oral surgeon, etc) in connection with our rendering dental treatment to you (i.e. to determine the results of cleanings, surgery, etc.)

____(initial) 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.).

____(initial) To certifying, licensing and accrediting bodies (i.e. state dental boards, etc.) in connection with obtaining certification, licensure or accreditation.

____(initial) To contact you in order to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

___ (initial) To email your x-rays, photos and treatment plan to a referring doctor or lab as needed.

____(initial) To leave voice messages, texts messages or email you regarding upcoming appointments.

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. Your rights regarding your health information:

___(initial) You may ask us to communicate with you in a confidential manner, ask to see or obtain photocopies of your health information and/or ask us to amend your health information if you feel that it is inaccurate or incomplete.

____(initial) I give permission for my/my child's photo to be displayed in this office.

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received, read and reviewed a copy of this notice of Privacy Practices, the consent to treatment and office procedures. I authorize use of my signature on and release of information for insurance submissions.

Signature of Parent /guardian of patient _____Date_____ _