

PERSONAL HEALTH INFORMATION AND PRIVACY (HIPPA)

To the Use and Disclosure of Health Information for Treatment, Payment or Dental Care Operations, I understand that as part of my health care, StarWhite Dental originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many dental/health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine dental care operations such as: assessing quality and reviewing the competence of dental/healthcare professionals.

I understand and have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that StarWhite Dental is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that StarWhite Dental reserves the right to change their notice and practices, prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should StarWhite Dental change their notice, they will send a copy of any revised notice to the address I have provided via US Mail or Email if I agree.

I understand that as part of this organization's treatment, payment or health care options, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax transmission.

Can confidential messages be left on your answering machine or voicemail? YES NO

Please list, if any, person(s) whom we may contact/inform about your dental condition, diagnosis and/or financial account:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

I fully understand and: Accept or Decline the terms of this consent.

Patient/Guardian Signature: _____ Date: _____