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Patient HIPAA Consent Form/Notices of Privacy Practices Acknowledgement

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, a copy of our Notice of Privacy Practices is posted for your review, and a copy is available at your request. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Illinois Law requires us (in addition to our attempt to obtain your written acknowledgement, discussed above) to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with; a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

HIPAA Patient Acknowledgement and Consent

Please sign this form below to "acknowledge" that a copy of our notice of privacy practices was available for your review and to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that I was able to review a copy of the Notice of Privacy Practices and consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Signature of Patient or Legal Guardian

Date