HARBORSIDE
DENTAL ASSOCIATES

Patient Acknowledgment and Consent Form

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice took effect January 1, 2018, and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at 231-347-7471.

We may use and disclose the following; your health information for different purposes, including treatment, payment and health care operations. Health information to a specialist providing treatment to you. Your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. We may send claims to your dental health plan containing certain health information.

Your health information to your family or friend or any other individual identified by you when they are involved in your care or in the payment for your care. We may use or disclose your health information when we are required to do so by law. Your protected health information for law enforcement purposes as permitted by HIPAA, as required by law or in response to a subpoena or court order.

Right to Request a Restriction: you have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to our office. Your written request must include 1 what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply.

_____ _____

Patient Signature Date

_____

Patient Name (Please Print)

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Patient Communications (HIPAA)

By law, without your authorization, HarborSide Dental Associates cannot communicate with:

1. Your spouse
2. Your adult Children or Caregivers
3. Your parents (if you are age 18 or over)

HarborSide Dental Associates may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or financial information

Please indicate below the names of people who we may communicate with regarding your appointment, medical/dental or account information:

☐ My Spouse _____

☐ My Adult Children _____

☐ My Parents _____

☐ My Caregiver _____

☐ Other _____

☐ I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member and/or guardian.

_____
Patient Name

_____ _____
Patient/Parent/Legal Guardian Signature Date