HIPAA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for many years. This form is a “friendly” version. A more complete text is posted in the office. This act lists out rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except when necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers when necessary and appropriate for your care.
2. It is the policy of the office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,___________________________________, do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

____ __________________________

Signature Date

Consent for release of protected health information to *non-healthcare professionals*

(This includes your spouse, parents, care-takers, etc.)

____ ____________________________
Name & Relation of Person Phone

____ ____________________________
Name & Relation of Person Phone

I,____, consent that my protected health information may be released to the following named individuals. I understand that, if at any time, I decide that I no longer want the following individuals to have access to my protected health information, I must notify the front office staff and sign an updated version of this form.

____ ____________________________
Signature Date

New England Dental Associates
233 West Central Street
Franklin, MA 02038
508-541-6886