Island Dental Associates HIPAA Release Form

Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996(HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form be kept confidential. The federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are premitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or at work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent we have already taken actions relying on your authorization.

For more information about our Privacy Practices, please contact our office.

I have reviewed Island Dental Associates' Notice of Privacy Practices and understand that more information is available upon request. I also certify that I have read and understand the above information to the best of my knowledge. I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I also give Island Dental Associates permission to discuss or release my dental records to the name listed below. If no other individuals are to recieve information, please place NONE in the spaces below.

Signature of Patient/Guardian _____

Relationship to Patient _____

Date _____

NO EXPIRATION UNTIL REQUIRED BY LAW