Rosemont Dental Center

Notice of Privacy Practices Consent Form

Rosemont Dental Center adheres to the HIPAA compliance policies as administered by the American Dental Association and the U.S. Department of Health & Human Services. For more information & complete regulations/guidelines, please visit hhs.gov/hipaa.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly and indirectly
- Obtain payment from third party payers - insurance company(ies)
- Conduct normal healthcare operations, such as quality assessments and physician certifications

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment, or healthcare operations. I also understand that Rosemont Dental Center is bound to abide by such restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Rosemont Dental Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: _____ Date: _____

Print Name: _____

Relation to Patient: _____