NOTICE OF PRIVACY PRACTICES AND PATIENTS CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME: _____ **DATE:** _____

I UNDERSTAND THAT UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ***(HIPAA),*** I HAVE CERTAIN PATIENT RIGHTS REGARDING MY PROTECTED HEALTH INFORMATION.

INDERSTAND THAT WESTSIDE DENTAL MAY USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS WHICH MEANS FOR PROVIDING HEALTH CARE TO ME, THE PATIENT; HANDING BILLING AND PAYMENT; AND , TAKING CARE OF OTHER HEALTH CARE OPERATIONS. UNLESS REQUIRED BY LAW, THERE WILL BE NO OTHER USES AND DISCLOSURES OF THIS INFORMATION WITHOUT MY AUTHORIZATION.

WESTSIDE DENTAL HAS A DETAILED DOCUMENT CALLED THE ***"NOTICE OF PRIVACY PRACTICES".*** IT CONTAINS A MORE COMPLETE DESCRIPTION OF YOUR RIGHTS TO PRIVACY AND HOW WE MAY USE DISCLOSE PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO READ THE ***"NOTICE"*** BEFORE SIGNING THIS AGREEMENT. IF I ASK, WESTSIDE DENTAL WILL PROVIDE ME WITH THE MOST CURRENT NOTICE OF PRIVACY PRACTICES.

MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN THE CHANCE TO REVIEW SUCH COPY OF THE NOTICE OF PRIVACY PRACTICES. MY SIGNATURE MEANS THAT AGREE TO ALLOW WESTSIDE DENTAL TO USE AND SISCLOSE MY PROTECED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I HAVE THE RIGHT TO REVOKE THIS CONSNT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT WESTSIDE DENTAL HAS TAKEN ACTION RELYING ON THIS CONSENT.

_____ _____

SIGNATURE (PATIENT OR LEGAL CUSTODIAN/AUTHORIZED REPRESENTATIVE) **DATE**

_____ _____

RELATIONSHIP TO PATIENT IF SIGNED BY ANOTHER PARTY **DATE**

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR ***"NOTICE"*** AT ANY TIME BY CONTACTING:

WESTSIDE DENTAL 50 AUERT AVE. UTICA, NY 13502 PHONE: (315)266-0000