everett endodontics

PRIVACY POLICY

ACKNOWLEDGEMENT OF PRIVACY PRACTICES FOR EVERETT ENDODONTICS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Healthy Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected healthy information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Additional Disclosure Authority:
Spouse Only: _____YES ____ NO Name: _____ DOB: _____
Other:
Name _____ Relationship: _____ DOB: _____

This authorization shall remain in force for 12 months following the date of my signature below. I understand that l have the right to revoke this authorization in writing, at any time, by providing written notification.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE PRIVACY POLICY OF EVERETT ENDODONTICS.

_____
(Printed Name of Patient or Authorized Representative/relationship if other than self)

_____
(Signature of Patient or Authorized Representative) (Date)
Note: If patient is under the age of 18, the signature of a parent or guardian is required.