Dental Care of Burlington
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HIPAA- Patient Acknowledgement and Consent Form
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I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights regarding how my personal health information (PHI) is kept private or the circumstances under which it is shared. I consent to this information being used for treatment, payment, and healthcare operations as set forth in the full Notice, including but not limited to:

Coordinating your treatment within this Practice and/or with other clinicians to achieve your best oral health;

Obtaining payment from third party sources on your behalf;

Administrative and managerial functions that we have to do in order to run our office.

I have been offered and/or accepted a copy of Dental Care of Burlington's full Notice of Privacy Practices containing the uses and disclosures of my protected health information (PHI). I understand you have the right to change and/or update your Notice of Privacy Practices and that it will always be available by request.

I understand that I may request in writing that you restrict uses of my PHI for treatment, payment, or healthcare operations. I also understand that you do not have to approve my request and that I may revoke this request at any time. I also understand that I may be required in writing to express any specific uses or disclosures of my PHI (eg, xrays to be sent to another clinician).

I acknowledge that I have been notified and offered a copy of the Notice of Privacy Practices.

_____ _____ Date: _____

X Patient Signature Patient Name (please print)