

NP - Notice of Privacy Practices

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

First Name - Patient *

Last Name - Patient *

Patient Date of Birth



SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

CHUNG TSEN DMD PLLC (DBA LAKEVIEW DENAL CLINIC)

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone - even family members - without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such

requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review on our website (>Patient Information />>Privacy Policy) or at the dental clinic.

You may refuse to sign this acknowledgement.

Statement of Privacy Practices

- I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Chung Tsen DMD PLLC (dba Lakeview Dental Clinic). The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.
- Chung Tsen DMD PLLC (dba Lakeview Dental Clinic) reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Additional Disclosure Authorization - In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is NO without checking the box in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

- Allow sharing of PHI with Spouse Only
- Allow sharing of PHI with member of my immediate family (Spouse, Children, Sibling)
- Allow sharing of PHI with member of my extended family (Parents, Grandchildren, etc)

Sharing of my PHI with individuals other than those listed above (type in their complete names, separated by comma):


Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: CONTACT PERSON SIGNATURE

Name of Patient, Parent, Guardian or Personal Representative

Signature of Patient, Parent, Guardian or Personal Representative *

Clear 

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.