Patient Name: _____ **Patient D.O.B**_____

Parent/Guardian Name: _____

HIPAA Privacy Regulations as of 2013

Patient privacy has always been a top priority at Austell Dental Associates. All of our staff members are dedicated to protecting our patients' privacy. The new HIPAA privacy regulations provide medical / dental practices and patients with an additional means to help guarantee that patient privacy is a top priority for all providers- physicians, dentists, hospitals and pharmacies-throughout the United States.

The new rules are beneficial for patients because they strengthen and set national standards for the privacy of your information. Specifically, the rules give patients more control over who can see their private dental information.

As an organization dedicated to safeguarding patients' dental records, we want patients to fully understand their dental privacy rights and know how their dental information is used. However, our number one job is to care for our patients. The final HIPAA privacy rule finds a balance. It protects patient information, but allows all essential activities to go on, which benefits all of us.

The Notice of Privacy Practices outlines specific details regarding HIPAA and your protected health information. In accordance with the federal HIPAA guidelines we ask that you sign a receipt of acknowledgement for the Notice of Privacy Practices. After reviewing the Notice of Privacy Practices, please let us know if you have any questions regarding HIPAA that we can answer for you.

ACKNOWLEDGEMENT OF RECEIPT FOR THE NOTICE OF PRIVACY PRACTICES

With the new privacy regulations, it is now necessary for us to have in writing who is able to seek care for the patient (if someone other than the patient, parent or guardian), and who we are able to release information to in person or over the phone.

List below the person(s) that Austell Dental Associates may speak to regarding your dental care:

_____ _____

_____ _____

_____ _____

By signing below you:

Give Austell Dental Associates permission to transmit your dental information electronically. Electronic transmissions include insurance claims, radiographs, treatment information and other dental information authorized by you.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Parent/ Legal Guardian: _____ **Date:** _____

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