ORCHARD DENTAL GROUP™
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PATIENT HIPPA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Orchard Dental Group of the practice's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that Orchard Dental Group restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that Orchard Dental Group is not required to accept requested restrictions but if agreement is approved, Orchard Dental Group is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Orchard Dental Group has taken action relying on this consent.

HIPAA Privacy issues can arise when using cell/smart phones in areas of Orchard Dental Group where patients and/or patient information may end up in photos or audio recordings. Patients and/or discussions may be in the background, and this information may be picked up in the photo or audio recording.

To ensure confidentiality and privacy, the use of camera phones, personal digital assistants (PDAs) for the purpose of video-taping patients for non-clinical purposes is strictly prohibited.

I authorize Orchard Dental Group to disclose my medical and payment information to the person(s) identified below:

_____

Relationship to Patient: _____

Patient Name: _____

Signature: _____

Date: _____