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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.***

### **THIS CONSENT DOES NOT EXPIRE**

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: \_\_\_\_\_