Health Care Insurance Portability and Accountability Act (HIPAA)

Patient Name: ____ DOB: __________________

☐ Self ☐ Representative

Representative's name & Relation to patient: ____

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I understand that as part of my health care, East County Oral Surgery originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that East County Oral Surgery Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review East County Oral Surgery Notice of Privacy Practices prior to signing this acknowledgement; that East County Oral Surgery reserves the right to change their Notice of Privacy Practices and prior to implementation of this, will mail a copy of any revised notice to the address I've provided if requested.

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, East County Oral Surgery, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who may contribute to my health care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to object to the use of my health information for directory purposes.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that East County Oral Surgery, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that East County Oral Surgery, has already taken action in reliance thereon.
- By law, we are unable to submit claims to payers under assignment of benefits without your signature. You will however be able to restrict disclosers to your insurance carrier for services for which you wish to pay "out of pocket" under the new Omnibus Rule. We will not condition treatment on you signing an authorization / acknowledgement, but we may be forced to decline you as a new patient or discontinue you as an active patient if you choose not to sign. I agree to all of the above Office Procedures of East County Oral Surgery, and give my authorization to all of the above procedures.

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Signature of Patient or Representative **Date**

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Signature of Office Member **Date**