cardinal
PEDIATRIC DENTISTRY

HIPAA Policy

Child(s) name:
_____
_____
_____
_____

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected healthcare 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 or indirectly (such as laboratories that interact with doctors and not patients)

- Obtain payment from third party payors

- Conduct normal healthcare operations such as assessments and physical certifications.

I have been informed that Cardinal Pediatric Dentistry has a more detailed version of this form available upon request. This more detailed version can be provided at any time.

I understand that I may request in writing that my private information be restricted as treatment is carried out, payment is obtained, and as health care operations are conducted. I understand that Cardinal Pediatric Dentistry is not required to agree with these requests, but if this office does agree we are bound to abide by the requested restrictions.

I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken relying on this consent. We respect your right to privacy of your healthcare information.

I authorize the following individuals to have access to this child's health information:

- _____
- _____
- _____
- _____

Guardian's Name _____

Guardian's Signature _____ Date _____