Supremia Dentistry
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SUPREMIA DENTISTRY, DR. EDMOND W. SUH, DDS

THIS NOTICE DESCRIBES HOW MEDICAL AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU OR OTHERS CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of Consent: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. By signing this form, you will consent for us to use and disclosure of your protected health information to carry out treatment, payment activities (including filing insurance), and health operations.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

* TREATMENT means providing coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
* PRESCRIPTION means obtaining any information that may be needed from the pharmacy to help provide me with the proper care. An example of this would be obtaining past prescriptions and dates they were filled.
* PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection, activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
* HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information (PHI), which you can exercise by presenting a written request to the Privacy Officer:

* The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

* The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
* The right to inspect and copy your protected health information.
* The right to amend your protected health information.
* The right to receive an accounting of disclosures of protected health information.
*The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of 4/14/2010 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We won't retaliate against you for filing a complaint.

HIPPA FORM

I understand that, under the HIPAA Act of 1996, I have certain rights to privacy regarding my PHI. 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 past and present prescription information from my pharmacies, local and mail order.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your 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 such 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 below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Notice of Privacy Practice: By signing this form, you acknowledge reading and being offered a copy of the Notice of Privacy Practices that gives a description of our treatment, payment activities, and health operations, the uses and disclosures we may make of your protected health information, and the important matters about your protected health information.

HIPAA Officer: Heather Hennen

REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Patient Name:

Last First MI

Preferred Name

Relationship to Patient:

SIGNATURE SECTION:

I give permission for the providers at Supremia Dentistry, Edmond W. Suh, DDS, to discuss my medical condition and care with the following individuals:

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Response Date: _____