Tsar Dental Excellence

HIPAA FORM

First Name: _____ **Last Name:** _____

Birthdate: _____(mm/dd/yyyy)

The **Department of Health and Human Services** has established a **"Privacy Rule"** to help ensure that personal healthcare information is protected for privacy. The privacy rule was also created in order to provide a standard for certain healthcare providers to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the **minimum** necessary information in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you, such as laboratories that only interact with doctors and not patients. As a result, we may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entities most often **do not** require patient consent.

You may refuse to consent to the disclosure of your personal health information. Your refusal must be in writing. Under law, we have the right to refuse to treat you if you decline the disclosure of your personal health information. However, you **cannot** revoke actions that have already been taken which relied on this or previously signed documents.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Signature:_____ **Date:**_____

Tel (561) 833-2364 • Fax (561) 471-1831 • TsarDentalExcellence@gmail.com • www.TsarDentalExcellence.com

11380 Prosperity Farms Road • Suite #101 • Palm Beach Gardens • FL • 33410