HILLSTREAM DENTAL

HIPAA: Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 [HIPAA] requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAAs requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of privacy practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires in addition to our attempt to obtain your written acknowledgement, discussed above] us to first attempt your written consent prior to disclosing any of your information except for our disclosures in connection with a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse-neglect investigation.

From time to time it may be necessary for us to disclose your information in connection with your treatment e.g., a referral to or consult with another dentist or health care professional, a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

As a healthcare provider, we may receive substance use disorder records, which are protected under title 42 of the Code of Federal Regulations Part 2. In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

Some information, such as HIV-related information, genetic information, alcohol and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Please list the names of any other individuals authorized to discuss your treatment, appointments and other information with our office.

_____ _____

Name Name

Patient Acknowledgement

_____ _____

Patient Signature Patient Name [Please Print]

Patient Consent

*Please sign this form to "Consent" to our disclosures of your information, that we may deem necessary in order to provide you with proper treatment.*I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that disclosures may not be the type listed above.

_____ _____

Patient Signature Patient Name [Please Print]

_____

Date