Portland Dental and Naturopathic Clinic

Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination, multiple health care providers may be involved in your treatment directly and indirectly. But, we will never share confidential details of your case with another provider without first asking for and obtaining your consent.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting a communicable disease in your area.
- To make required reports to the police, such as instances of abuse
- To obtain payment from third party payers, such as insurance companies.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

_____Please do not phone me at home, use this alternate phone number_____

_____Please do not phone me at work, use this alternate phone number_____

_____Please do not leave messages on my phone

_____Please do not contact me by email

_____Please send mail including my bills to this alternate address_____

_____

_____Other requests (please describe)_____

_____

Patient's name (Please print. include parent/guardian name if patient is a minor)

_____ ____/_____/_____

Patient signature (parent/guardian if minor) Date