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NOTICE OF HIPAA COMPLIANCE

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally, are kept strictly confidential. I have certain rights to privacy regarding myself, my child, children or legal guardian, and the protected health information. I understand that this information can and only will be used to:

Conduct, plan and direct my child, children or legal guardian, treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I also understand that this gives consent to Stone Oak Pediatric Dentistry and its representatives to send phone, text or email communications regarding my child, children or legal guardianship.

Signature______________________________________ Date: _____________________

Print Your Name: ____

Response Date: [ ]