Progressive Periodontics &
Implant Dentistry
MARC E. GORDON D.M.D.

Patient Consent Form: Use and Disclosure of Health Information Protected Under HIPAA

Pursuant to the information contained in the Notices of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO). I am aware that I have a right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting this facility. I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Options. Further, I give my consent for the use of mail or e-mail to designated locations, including my home, and to other relevant healthcare providers to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Options.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Options (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent. Services are provided without regard to sex, race, color, religion, national origin, or disability.

Patient's Name: _____

Patient's Signature: _____ Date: _____

If applicable, Legal Guardian_____

Notice of Privacy Practices: Use and Disclosure of Health Information Protected Under HIPAA
This document provides a summary of how dental information about you may be used and disclosed and how you can obtain access to this information.
We understand that dental information about you and your health is personal. We are committed to protecting your dental information. It is our policy that the privacy of your protected health information (PHI) be uncompromised while still allowing necessary access to assure that the dental care you receive is appropriate and of the highest possible quality.
We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner; known as Treat, Payment, and Healthcare Options (TPO).

1. To provide dental treatment and/or services.
2. To bill third party payers, when appropriate, for treatment you receive from us.
3. To facilitate the mechanisms, which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation, which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health and we will not use your PHI for uses outside our facility without your express permission.
You have the following rights regarding the dental information we maintain about you.
1. To inspect and copy information that may be used to make decisions about your care.
2. To request restrictions or limitations on the dental information we use or disclose about you for fair treatment, payment, or healthcare options. While we are not required to agree to your request, we will do our utmost to comply unless the information is needed to provide emergency treatment.
3. To amend the PHI we maintain if you believe that the dental information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.
Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitted in writing. You will not be penalized for filing a complaint.
Patient Acknowledgement:

I acknowledge receipt of this information regarding my right to PHI privacy.

Signature: _____ Date: _____

Print Name: _____