Claude A. Hearn, DMD
HIPPA Acknowledgement

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while in effect. By signing this you agree that we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Common (but not limited to) Reasons for Our Use in Disclosure of Patient Health Information

Treatment: We will use your health information to provide you with dental treatment or services, such as cleaning or examining your teeth or performing dental procedures. We may disclose health information about you to dental specialists, physicians, or other health care professionals involved in your care.
Payment: We may use and disclose your health information to obtain payment from health plans and insurers for the care that we provide to you.
Health Care Operations: We may use and disclose health information about you in connection with health care operations necessary to run our practice, including review of our treatment and services, training, evaluating the performance of our staff and health care professionals, quality assurance, financial or billing audits, legal matters, and business planning and development.
Appointment Reminders: We may use or disclose your health information when contacting you to remind you of a dental appointment. We may contact you by using a postcard, letter, voicemail, or email.
Treatment Alternatives and Health-Related Benefits and Services: We may use and disclose your health information to tell you about treatment options or alternatives or health related benefits and services that may be of interest to you.
Disclosure to Family Members and Friends: We may disclose your health information to a family member or friend who is involved with your care or payment for your care if you do not object or, if you are not present, we believe it is in your best interest to do so.

For more information please contact the office manager.

Authorized Signature:____Date:_____________

I hereby give permission for Dr. Hearn to give information to the following family members/persons:

_______________________________________ _______________________________________

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