Cold Springs Dental Office * 2900 Cold Springs Rd * Placerville, Ca 95667

Privacy Act and Dental Material Fact Sheet

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to revise and secure a copy of you Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke the consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke the consent is not affected.

I understand that the Dental Material Fact Sheet (DMFS) describes and compares the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The DMFS is intended to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.

I understand that the complete HIPPA Privacy Act and complete DMFS are available to me at any time.

Signed this _____day of _____, 20_____.

Print Patients Name:_____

Relationship to Patient:_____

Signature:_____