

**VALERIE M. PRESTON DDS, PA
RALEIGH CENTER FOR COSMETIC & RESTORATIVE DENTISTRY
HIPAA POLICY STATEMENT**

Valerie M. Preston and Staff consider the privacy, confidentiality, and security of patient's health information as an essential component of our business relationship with our clients. Safe and secure handling of the patient information provided to us by you is a crucial aspect of our practice, and we undertake this responsibility very seriously. Toward that end, we are committed to practices and procedures that are consistent with the standards mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which will assist our patient's in complying with the regulatory requirements imposed upon them by HIPAA.

Dr. Preston also has a program in place to monitor new developments and changes to the HIPAA standards, and we intend to adjust our policies, procedures and, if necessary, the confidentiality agreement so that our patients may remain in compliance with applicable HIPAA regulations.

Of course, our efforts alone are insufficient to ensure that our patient's achieve and maintain HIPAA compliance. Since HIPAA standards are directly applicable to our dental practice, the bulk of compliance efforts and activities will fall upon our patients that are covered entities of HIPAA. The policies and procedures that we employ comprise only a part of all that is required of covered entities under the HIPAA standards and mandates. Therefore, in order for our patients to be fully compliant with HIPAA, they will need to become fully versed in the HIPAA regulations. We have attached a form for patients/responsible parties to sign, date and return to our office stating that you understand and are aware that our dental practice is abiding by the HIPAA regulations and we are protecting our patient's health and financial information in a responsible and legal manner.

Thank you to all our patients for cooperation.

Valerie M. Preston DDS, PA

VALERIE M. PRESTON, DDS, PA
RALEIGH CENTER FOR COSMETIC & RESTORATIVE DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-Mail _____

Patient #: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practices, including any revisions at any time by contacting: (919)518-0540 or 614dentalspa@bellsouth.net

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my Consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representation on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient: _____

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____