HIPAA RELEASE FORM

Kent Burnett DDS

1711 NW Grant Ave.
Corvallis, OR 97330
(541) 754-1668

420 Smith St.
Harrisburg, OR 97446
(541) 995-8234

Please email completed form to: office@kentburnettdds.com

CONSENT FOR RELEASE OF INFORMATION

I understand that, under the Health Insurance Portability & Privacy Accountability Act of 1996 (HIPAA), that I have certain rights to privacy in regards to my protected health information. I authorize Kent D. Burnett, D.D.S. to release this information to: conduct normal health care operations, obtain payment from third-party payers, make an appeal on my behalf, and plan my treatment and follow up with other health care providers.

CHANGE OF INSURANCE CARRIER(S) AND/ OR COVERAGE

I understand that it is my responsibility to inform Kent D. Burnett, D.D.S. of any changes in my insurance carrier and/or coverage. Any charges that are acquired as a result of not informing Kent D. Burnett, D.D.S. of these changes are my financial responsibility and must be paid within 60 days of the date of service.

RECEIPT OF PRIVACY POLICES AND PRACTICES

I have received a copy of Kent D. Burnett, D.D.S.'s Privacy Polices and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing to restrict how my private information is disclosed to carry out treatment, or for payment by a third-party payer.

Patient signature or
Legal Representative:_____ Date:_____

Patient Name:_____ Date of Birth:_____

Legal Representative Information:

Name:_____ Relationship to patient:_____

Address:_____

Phone #:_____

Kent Burnett DDS

NOTICE OF PRIVACY PRACTICES

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

Our Legal Duty

Federal and state law requires us to maintain the privacy of your health information. That law requires us to give you this notice about this notice about our privacy practices, legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 13, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our policy practices or for additional copies of this notice, please contact us using the information listed in this notice.

Uses And Disclosure Of Health Information

We use and disclose health information about treatment, payment and health care operation. For example:

Treatment: We may use your health information for treatment or disclose to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose you health information to obtain payment for services we provide to you. We may disclose you health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operation: We may use and disclose you health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence of qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On your Authorization: You may give written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose you health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose you health information to a family member, friend or other person to extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in you best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

Disaster Relief: We may use or disclose you health information to a public entity authorized by laws or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your health information as authorized by law for the following purposes deemed to be in the public or benefit as required by law;

For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employees regarding work related illness or injury;
To report adult abuse or neglect or domestic violence;
To health oversight agencies;
In response to court and administrative orders and other lawful purposes;
To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises;
Reporting crimes in emergencies, and for purpose of identifying or locating a suspect or other person; To coroners, medical examiners, and funeral directors;
To organ procurement organizations;
To avert a serious threat to health or safety;
In connection with certain research activities;
To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
To correctional institutions regarding inmates,
And authorized by state worker's compensation laws.

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost based fee that may include labor, copying costs and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates or we disclosed your health information over the past 6 years (but not before April 13,2003). That list will not include disclosures for treatment, payment, and health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make it in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request. AMENDMENT: You have the right to request that we amend you health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

Questions and Concerns: If you have any questions or concerns contact us using the information listed a the end of this notice, If you believe that: We may have violated your privacy rights, we made a decision about access to your health information incorrectly, our response to a request you made to amend or restrict the use of or disclosure was incorrect, or we should communicate with you by alternative means or at alternative locations. You may also submit a written complaint to the U.S. Dept. of Health and Humans Services. We will provide you with the address to file your complaint. We support you right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept. of Health and Humans Services.

Provider's Office:
Kent D. Burnett D.D.S.
1711 NW Grant Ave Corvallis, Or 97330
Phone: 541-754-1668 Fax: 541-758-3010

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NOTICE OF PRIVACY PRACTICES RECEIPT

Name:_____

Address:_____

Telephone:_____

Acknowledgment:

I _____ acknowledge that I have received a Notice of Privacy Practices from Dr. Kent Burnett D.D.S.

Signature:_____Date_____

If a personal representative signs this authorization on behalf of the individual complete the following:

Personal Representative's Name:_____

Relationship to individual:_____

OFFICE USE ONLY:

Good faith effort to obtain acknowledgment of receipt:

_____

Describe your good faith effort to obtain the individuals signature on this form:

_____

Describe the reason why the individual would not sign this form:

_____

Signature (office use): I attest that the above information is correct.

Signature:_____Date_____

Print Name:_____Title_____

Include this acknowledgment of receipt in the patients records.