Offices of Heather Bond Southard, DDS

Please list the names of the persons to whom we may disclose the patient's private health information and relationship to the patient:

Emergency Contact Name/Relationship: ____

Emergency Contact Phone #: (_________) _______________________

Name: ___________________________________ Relationship: ___________________________

Name: ___________________________________ Relationship: ___________________________

Name: ___________________________________ Relationship: ___________________________

Please list names of the organization(s) to which we may send notifications verifying appointments (for work or school excuses, etc):

School: ____

Work: ____

Other: ____

HIPAA POLICY

I understand that, under the Health Insurance Portability Act (HIPAA), I have certain rights to privacy regarding my protected information. I understand that this information may be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I understand that, upon request, I have the right to receive a complete copy of your Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the practice has the right to change its Notices of Privacy Practices if necessary and that I may contact this office at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you agree to them then you are bound to abide by such restrictions.

____ ______________________

Signature of patient/parent or guardian Date