DENTAL IMPLANT CENTER
OF ROYAL OAK

Privacy Policy & HIPAA Authorization

Patient Name: _____ Date: _____

By signing, I authorize **Dental Implant Center of Royal Oak** to use/or disclose certain protected health and/or financial information about me to any doctor or health care facility that they refer me to with my consent and understanding OR to _____

This authorization permits **Dental Implant Center of Royal Oak** to use and/or disclose the following individually identifiable health information about me, including but not necessarily limited to: handwritten, digital notes and chartings, diagnosis, radiographs, photographs, lab slips, prescriptions, therapeutic, treatment records. The information will be used or disclosed for the following purposes: To assist other healthcare providers/entities in providing your health care OR for insurance billing and receiving payments on your behalf. (If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.") Included in this section is any entity that you have authorized to receive your medical records. In such cases, ALL your chart data will be provided unless the request explicitly requests only specific information.

☐ I **DO** consent to send and receive *text messages that do not use encryption services* to and from this office and to have my insurance claims sent on my behalf. All email communication IS SENT using an encryption service. **X _____ (Initial)**

☐ I **DO** give advance permission to **Dental Implant Center of Royal Oak** to release my dental radiographs and/or records *to my personal email address only* if I ever request this in the future. **X _____ (Initial)**

-----OR-----

☐ I **DO NOT** consent to receive email communication and/or text message that do not use encryption services. I understand that all communication and documents must be picked up in person or sent via certified mail via scanned documents on a CD disc at my personal expense. All electronic insurance claims will be my sole responsibility. X_____ (Initial)

I do not have to sign this authorization to receive treatment from **Dental Implant Center of Royal Oak**. I understand that if I refuse to sign this form, the office cannot bill my insurance on my behalf and that I will be responsible to pay for all services in advance. I also have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it might be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 4251 Coolidge Hwy. Royal Oak, MI 48073, (248) 547-3700.

Our Privacy Policy is framed in the reception area. You may request a copy of our Privacy Policy at any time. By signing below, you are acknowledging that you have reviewed and received (if requested) this Privacy Policy and you are aware of your rights.

I HAVE BEEN OFFERED A PRINTED COPY OF THE FULL HIPAA LAW & PRIVACY POLICY AND UNDERSTAND THAT I MAY REVOKE THIS SIGNED DOCUMENT AT ANYTIME BY CONTACTING THIS DENTAL OFFICE.

Signature of Patient/Legal Guardian: _____ Date: _____