Northern smiles orthodontics
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Notice of Privacy Practices and Dental and Medical Information Release Form (HIPAA)

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA") I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.

* Obtain payment from third-party payers.

* Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I can receive your complete Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Please list approved telephone numbers we may use to contact you regarding your appointments. dental treatment concerns, and billing.

The following is a list of people **this clinic** may discuss my dental care needs with, including billing and appointment scheduling issues:

Name:	Relationship:

_____ _____ _____

Patient's Name **Signature of Responsible Party** **Date**