PEACHTREE DUNWOODY
DENTAL GROUP

Notice of Privacy Practices

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal healthcare information is protected for privacy. The Health Insurance and Portability and Accountability Act of 1996 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used by us in any form are kept confidential.

As our patient we want you to know that we respect the privacy of your personal medical/financial records and will do all we can to secure and protect that privacy. Our staff is trained to release only the minimum information to only those in need of your healthcare information regarding treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

The following rights may be exercised by presenting a written request to our Privacy Officer with respect to your protected health information:

- The right to inspect and copy your protected health information
- The right to amend your protected health information
- The right to obtain a copy of this notice upon request
- The right to request restrictions on information for certain uses including disclosures to family members or any other person identified by you

You may refuse to consent to the use or disclosure of your personal health information - this must be done in writing. However, under this law we may also refuse to treat you as our patient, if you should refuse to disclose your personal health information.

We would like to assure you, as our highly valued patient, that we are in compliance with government rules and regulations concerning your privacy. Our practice will continually strive to comply with “HIPAA” guidelines concerning the proper disclosure of your Personal Health Information.

Jeremy Rosenberg, D.D.S.
David Camp, D.D.S.

Notice of Privacy Practices Consent

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this practice at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

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 the practice is not required to agree to my requested restrictions; however, if the practice does agree then it is bound to abide by such restrictions.

Patient Name (please print):_____

Signature:_____

Date:_____

Signature of Parent or Guardian:_____