HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Notice of Privacy Practices

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

☐ * **By checking this box, I acknowledge that I have reviewed the Notice of Privacy Practices at the MSU,M Dental Clinic. This notice is posted on the MSU,M Dental Clinic website and at the clinic front desk.**

MSU,M Dental Clinic Patient Bill of Rights

1. To be treated with respect and consideration for their dental, medical and personal needs.

2. To receive treatment that meets the standard of care in the dental hygiene profession, which includes appropriate dental hygiene care based on individual needs.

3. Confidentiality of their dental records. Patients must provide written approval for the release of records to any individual outside the department.

4. To have access to complete and current information about their condition.

5. To be treated as partners in care by participating in the planning of their dental hygiene treatment. This includes the opportunity to discuss recommended treatment and alternatives and expected outcome of various treatments with the instructor and the student hygienist at the time of initial evaluation. Patients needing treatment that the dental hygiene clinic cannot provide will be appropriately referred.

6. To receive reasonable continuity of care and completion of treatment.

7. To have the right to refuse treatment. Those who refuse treatment shall be informed of the risks associated with no treatment and the individual's dental record will be so documented.

8. To be fully informed, prior to or at the time of treatment planning, of the cost and limitations of treatment.

9. To be asked to sign an informed consent form which, in part, recognizes that visits to the MSU Dental Clinic do not take the place of regular examination by a dentist.

10. To understand the scope of practice treatment at the MSU Dental Clinic includes a dental hygiene treatment plan, scale/polish, periodontal treatment, personal oral hygiene education, radiographs, fluoride therapy, sealants, bleaching trays, and limited restorative treatment (spring semester only).

11. To find the MSU Dental Hygiene Program complies with the infection control guidelines recommended by the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA).

12. To find the MSU Dental Hygiene Program does not discriminate against any patient due to race, religion, color, veteran's status, national origin, sex, sexual preference, age, marital status, physical disability, creed, status due to receipt of public assistance, or inclusion in any other group or class against which discrimination is prohibited by Title VII of the civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Chapter 363 of Minnesota Status and other applicable state or federal laws.

13. To return to their regular dentist for a complete dental exam or have an exam done here when a dentist is present.

14. To be informed of the student dental hygienists and faculty members' names.

☐ ***By checking this box, I acknowledge that I have reviewed the Patient Bill of Rights and have opportunity to ask any questions through email or in person.**

Response Date: ____________