Patient Acknowledgement (HIPPA)

医療保険の相互運用性と説明責任に関する法律

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.
Existing Michigan Law requires(in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.
From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below that you have received, and /or reviewed the Notice of Privacy Practices. 医療保険サービス提供者、保険請求作成者、健康保険プランによる医療情報への適切なアクセス及び使用を承認致します。

We are going to be communicating and sending statements by email and text messages in the future. Please provide your email and phone number to stay informed: 今後の予約確認・請求書などEメール・テキストでの連絡を了承致します。

Authorization for Release of Information to Family Members and Friends

ご本人の医療情報開示許可者リスト

Name 氏名	Phone number 電話番号	Relationship 患者との関係

The following information has special protection under Michigan law and will not be disclosed without the patient's permission. This information will be made available to the people I've listed above only if I indicate may approval by initialing the lines below: ミシガン州の法律により情報を開示する為には明確な許可が必要です。この情報は、所定の箇所に私のイニシャルがある場合のみ上記に記載された人物への情報開示を許可します。

_____Dental Treatment Plans 治療プラン/Dental Records 治療記録/X-rays release レントゲン譲渡

I understand that I can update this form at any time in writing. This form does not expire unless revoked. このリストはいつでも書面にて更新する事ができ、取り消しされない限り有効期限はありません。

Patient Name 患者氏名_____ Date of Birth 生年月日 _____

_____ _____

Signature of Patient/Legal Representative 署名 Date 日付(mm/dd/yyyy)

Email メルアド_____

Cell Number 携帯番号 _____