Advanced Dentistry of Richmond
Ursula Klostermyer DDS, PhD
7204 Glenn Forest Dr. #203
Richmond, VA 23226

Notice of Privacy Practices (HIPAA Consent)

Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. We have provided you with a copy to view prior to signing this consent. By signing this form, you agree to our use and disclosure of your protected health information for treatment, payment and healthcare operations. You have a right to revoke this consent, in writing, signed by you. This form is provided to comply with the Health Insurance Portability and Accountability ACT of 1996(HIPAA).

Do you give us permission to leave personal medical/dental information on your voicemail/answering machine/email? ( ) Yes ( ) No

Home Phone:_____ Cell Phone:_____ Email:_____

How we use electronic messaging:

- Reminders of appointments or actions for you to take before or after an appointment.
- How to participate in patient satisfaction surveys.
- Information regarding insurance, billing, account balances.
- Communication with other dental/medical offices regarding your treatment.

Do you give us permission to discuss your medical/dental information with anyone other than yourself? ( ) Yes ( ) No

Name	Relationship	Telephone #

Photos:

- Photos/x-rays received from patient or another medical/dental professional will be uploaded to the patient's electronic chart.
- Photos/x-rays taken by staff, to document a condition or to aid in diagnosis will be uploaded to the patient's electronic chart. The photos/x-rays may also be shared with other dental or health care professionals to help with the treatment needed.

Patient Acknowledgement and Agreement:

- For email and text communication, I understand that information is sent in an encrypted manner, but there is a risk it could be accessed inappropriately. Advanced Dentistry of Richmond cannot guarantee but will use reasonable means to maintain the security and confidentiality of the messages we send and receive.
- I have read and fully understand this consent form. I understand the risks associated with the use of electronic messaging between Advanced Dentistry of Richmond and myself, and I consent to the conditions and instructions outlined.

This authorization will remain in effect unless revoked by patient.

_____ _____
Signature of Patient or Guardian Date