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PARTE 3

3. Patient HIPAA Consent and e-mails and texting

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Patient consent for use and disclosure of Protected Health Information (PHI) Acknowledgment of receipt of Notice of Privacy Practices

*Consentimiento del paciente para usar y compartir informacion personal de salud y confirmacion de recibo de la Nota de Practicas de Privacidad

I acknowledge that I have been provided with TRUDENT FAMILY DENTISTRY., "Notice of Privacy Practices"., and I am giving my consent for the use and disclosure of Protect Health Information as required and / or permitted by law.

*Confirmo que se me ha proveido con la "Nota De Practicas De Privacidad" de TRUDENT FAMILY DENTISTRY., y doy mi consentimiento para usar y compartir Información Personal De Salud como lo permita y/o requiera la ley.

PPatient Name: (please print)

*Nombre Del Paciente: (nombre en letra de molde por favor

PPatient Signature (or legal representative; proof may be requested)

*Firma Del Paciente: (o representante legal; prueba puede ser requerida)

DDate: (dd/mm/yy) _____

*Fecha: (dd/mm/aa)

EMAIL/TEXT MESSAGE TO Mobile Phone CONSENT FORM

*CONSENTIMIENTO DE CORREO ELECTRONICO/MENSAJES DE TEXTO A MOVIL

Purpose: This form is used to obtain your consent to communicate with you by email/mobile text messaging regarding your Protected Health Information. TRUDENT FAMILY DENTISTRY., (TFD) offers patients the opportunity to communicate by email/mobile text messaging. Transmitting patient information by email/mobile text messaging has a number of risks that patients should consider before granting consent to use email/mobile text messaging for these purposes. TFD will use reasonable means to protect the security and confidentiality of

email/mobile text messaging information sent and received. However, TFD cannot guarantee the security and confidentiality of email/mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email/mobile text messaging between TFD and me and consent to the conditions outlined herein. Any questions I may have had were answered.

*Propósito: Esta forma es usada como consentimiento de usted para comunicarnos vía correo electrónico/mensaje de texto a móvil en referencia a su Información de Salud Protegida. TRUDENT FAMILY DESTISTRY., (TFD) ofrece a sus pacientes la oportunidad de comunicación vía correo electrónico/mensaje de texto a móvil. Transmitir información vía correo electrónico/mensaje de texto a móvil tiene numerosos riesgos que el paciente debe considerar antes de otorgarnos este consentimiento para estos propósitos. TFD usara formas razonables de proteger confidencial y seguro la información mandada a usted vía correo electrónico/mensaje de texto a móvil. De todas formas, TFD no podrá garantizarle proteger confidencial y seguro la comunicación vía correo electrónico/mensaje de texto a móvil y no será en ninguna forma responsable si esta información confidencial es usada inadvertidamente por otros.

Yo comprendo haber leído y completamente entendido el consentimiento de esta forma. Yo comprendo los riesgos asociados con la comunicación vía correo electrónico/mensaje de texto a móvil entre TFD y yo consiento a las condiciones que me han sido dadas. Cualquier pregunta que yo haya tenido me a sido respondida.

Patient Acknowledgment & Agreement / *Reconocimiento y Acuerdo del Paciente

My Consented Email Address is:

*Mi Correo Electrónico Consentido es:

My Consented for Text Messaging to:

*Mi Mensaje de Textos Consentido a:

X _____

Patient Signature

* Firma del Paciente

Date

*Fecha

In Case of Any Emergency Please Call 911 or Proceed to the Nearest Emergency Room, DO NOT USE THIS WAY OF COMMUNICATION FOR THAT PURPOSE.

En Caso de Cualquier Emergencia Por Favor Llame al 911 o Proceda al Centro de Emergencia Cercano, NO USE ESTA FORMA DE COMUNICACIÓN PARA ESE PROPOSITO

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PARTE 6

6. Option (2) – To REQUEST using E-mail any Medical Record FROM other Practices

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION
FROM OTHER HEALTHCARE FACILITIES

Patient Name: _____

SS#: _____

Telephone #: _____ Date

of Birth: ____ / ____ / ____

Address: _____

City: _____ State: _____ Zip: _____

Name of Healthcare Facility from which Records are Requested:

Ph: _____

Fax: _____

(Please Print)

Address: _____

City: _____ State: _____ Zip: _____

Dates of Treatment Requested: _____

Reason for Disclosure: _____

MAIL INFORMATION TO:

TRUDENT FAMILY DENTISTRY.

9332 SW 56th Street Miami, FL 33165

Or FAX TO: 305.XXX.XXXX

Or Email To: trudentfamilydentistry@gmail.com

I authorize TRUDENT FAMILY DENTISTRY., (TFD) to obtain the health information indicated below AND for the purpose of alternative means of confidential communication the use of their Email Address.

TFD offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. TFD will use reasonable means to protect the security and confidentiality of email information sent and received. However, TFD cannot guarantee the security and

confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information. I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication via email and consent to the conditions outlined herein. Any questions I may have had were answered.

Check a Box

Complete Record
Radiology Reports
Lab Reports
Pathology Reports
Other (Specify)
Other (Specify)

SPECIFIC AUTHORIZATIONS

The Following Information will not be released unless you specifically authorize it by marking the relevant box(es) below:

Drug/ Alcohol Abuse or Treatment
HIV/ AIDS Test Results or diagnoses
Genetic Testing Information
Psychotherapy Notes (The release of Psychotherapy Notes required a separate authorization)

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____/_____/_____
Signature of Patient or Legal Representative

Date Signed:

Printed Name: _____
Relationship if not Patient: _____

****If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care).**
For a deceased patient: A death certificate coupled with executor or administrator of estate paperwork must accompany authorization.
Exception: parent signing for patient under the age of 18.

****For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required coupled with the document****

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PARTE 7

7. Statement for E-Mail and Fax Cover Page

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E-MAIL CONFIDENTIALITY STATEMENT

IMPORTANT CONFIDENTIALITY NOTICE: This transmission contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPAA) Privacy and Security Rule under 45 CFR Part 160 and 45 CFR Part 164 . This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, or an employee or agent responsible for delivering this electronic mail transmission to the intended recipient, you are notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender immediately and destroy all copies of the materials sent.

FAX COVER PAGE CONFIDENTIALITY STATEMENT

IMPORTANT CONFIDENTIALITY NOTICE: This transmission contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPAA) Privacy and Security Rule under 45 CFR Part 160 and 45 CFR Part 164 . This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient, or an employee or agent responsible for delivering this facsimile mail transmission to the intended recipient, you are notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender immediately and destroy all copies of the materials sent.

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PARTE 8

8. Employee Agreement

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employee hipaa compliance signature form

TRUDENT FAMILY DENTISTRY

MY commitment to compliance

Employee Name

Date

I have read and understand our office's Employee HIPAA (Privacy Rule) Compliance Manual. I agree to do all I can, within my area of responsibility to maintain up-to-date knowledge about federal and state laws and program requirements. I will comply with these requirements to the best of my ability, and to immediately let the Compliance Officer know if there is any area where I feel our office is not in Compliance with these laws and program requirements. Our policy is a simple, yet powerful four-step process:

Keep Up-to-date, educate, comply, and audit/ correct.

We seek to maintain up-to-date knowledge about federal and state law pertaining to protection of our patients Personal Health Information (PHI).

We educate our employees and keep them up-to-date about federal and state law as it applies to PHI.

Our policy is to comply with all federal and state law governing PHI.

We desire that all our employees are particularly cognizant of the fact PHI must be treated with utmost attention, accuracy, honesty, and integrity. We seek to educate and carry out these policies with all our employees, managers, clinicians, and where appropriate, contractors and other agents.

I agree with our policy and will do all I can to comply with all regulatory laws pertaining to PHI. I understand that our office has an open door policy and I may discuss any problems I feel may occur with PHI without worry of recourse with my supervisor or other supervisors.

confidentiality statement

It is the purpose of this organization to protect the confidentiality of the medical records and privacy of all patients.

The patient has a legal right to privacy concerning his/her medical record. It is the obligation of the Organization to uphold that right. For this reason, no member of the organization to whom medical records or patient information is available may in any way violate this confidentiality except with the written consent of the patient and in accordance with policy, rules and regulations, and State Administrative Code.

I have read the above statement and agree to abide by it wholeheartedly.

X _____
Employee Signature

X _____
Compliance Officer Signature

Page 1 of 1

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PARTE 9

9. Business Associates Agreement

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HIPAA PRIVACY COMPLIANCE AGREEMENT
FOR BUSINESS ASSOCIATES

THIS AGREEMENT is made this _____ day of _____, 20____, by
and among

(hereinafter known as "Cover Entity")

(hereinafter known as "Business Associate")

Covered Entity and Business Associate shall collectively be known herein as "the parties".

WHEREAS, Covered Entity is a health care provider whose activities are generally described
as:

WHEREAS, Business Associate is in the business of providing services to health care industry
and its
activities are generally described as:

WHEREAS, Covered Entity wishes to commence a business relationship with Business
Associate that shall
be memorialized in a separate services agreement which has yet to be executed;

WHEREAS, the nature of the prospective contractual relationship between Covered Entity and
Business
Associate may involve the exchange of Protected Health Information ("PHI") as that term is
defined under the
Health Insurance Portability and Accountability Act 1996 ("HIPAA") as amended by Health
Information

Technology for Economic and Clinical Health Act of 2009 ("HITECH Act")' including all pertinent regulations issued
by the Department of Health and Human Services ("HHS");

The premises having been considered and with acknowledgment of the mutual promises and of other good and
valuable consideration herein contained, the Parties, intending to be legally bound, hereby agree as follows:

A. Definitions.

Breach. "Breach" has the same meaning as this term has in 13400 of Health Information
Technology for Economic and Clinical Health Act of 2009 ("HITECH Act").

Business Associate. "Business Associate" shall mean _____.

Covered Entity. "Covered Entity" shall mean _____.

Designated Record Set. "Designated Record Set" has the same meaning as this term has in
45CFR 164.501.

Individual. "Individual" has the same meaning as this term has in 45CFR 164.501.

Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable
Health Information at 45CFR Part 160 and Part 164, Subparts A and E., as amended
by the
HITECH Act.

Protected Health Information. "Protected Health Information" (or "PHI") has the same meaning
as this term has in 45CFR 160.103 (as amended by the HITECH Act), limited to the
information
created or received by Business Associate from or on behalf of Covered Entity.

Required By Law. "Required By Law" has the same meaning as this term has in 45CFR
164.501.

Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human
Services or his designate.

Security Standards. "Security Standards" mean the security standards for protection of PHI
promulgate by the Secretary in Title 45 C.F.R.

11. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall
mean

Protected Health Information (PHI) that is not secured through the use of a technology or methodology specify by the Secretary in regulations or as otherwise defined in the *13402(h) of the HITECH Act.

12. Any prospective amendment to the laws referenced in this definition section prospectively amend this agreement to incorporate said changes by Congressional act or by regulation of the Secretary of HHS.

B. Obligations and Activities of Business Associate.

1. Business Associates agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

2. Business Associate agrees to employ administrative, physical, and technical safeguards meeting required Security Standards for business associates as Required By Law to prevent disclosure or use of PHI other than as allow by this Agreement.

3. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI held by Business Associate in violation of the requirements of this Agreement.

4. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

5. If a breach of unsecured protected health information occurs at or by Business Associate, the Business Associate must notify Covered Entity following the discovery of the breach without unreasonable delay and, in all cases, no later than 60 days from the discovery of the breach. To the extent possible, the Business Associate should provide the Covered Entity with the identification of each individual affected by the breach as well as any information required to be provided by the Covered Entity in its notification to affected individuals. Business Associates shall comply with all regulations issued by HHS and applicable state agencies regarding breach notification to Covered Entity.

6. Business Associates agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associates with respect to PHI.
7. Business Associate agrees, at the request of Covered Entity, to provide Covered Entity (or a designate of Covered Entity) access to Protected Health Information in a Designated Record Set in prompt commercially reasonable manner in order to meet the requirements under 45 CFR *164.524.
8. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR *164.526 at the request of Covered Entity or an Individual, in a prompt and commercially reasonable manner.
9. Business Associates agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary (including official representatives of the Secretary), in a prompt commercially reasonable manner for purposes of determining Covered Entity's compliance with the Privacy Rule.
10. Business Associate shall, upon request with reasonable notice, provide Covered Entity access to its premises for a review and determination of its internal practices and procedures for safeguarding PHI.
11. Business Associates agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR *164.528.
12. Business Associate agrees to provide to Covered Entity or an Individual, in a prompt commercially

reasonable manner, information collected in accordance with this Agreement, to permit Covered

Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR *164.528.

C. Permitted Uses and Disclosures by Business Associate.

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information, as follows:

1. On behalf of, Covered Entity, provided that such use or disclosure would not violate the Privacy

Rule if done by Covered Entity.

2. Except as otherwise limited in this Agreement, Business Associates may disclose Protected Health

Information for the proper management and administration of the Business Associate, provided

that disclosures are required by law, or Business Associates obtains reasonable assurances from

the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the

person, and the person notifies the Business Associate of any instances of which it is aware the

confidentiality of the information has been breached.

D. Obligations of Covered Entity

1. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices

of Covered Entity in accordance with 45 CRFR *164.520, to the extent that such limitation may

affect Business Associate's use or disclosure of Protected Health Information.

2. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by

Individual to use or disclose Protected Health Information, to the extent that such changes may

affect Business Associate's use or disclosure of Protected Health Information.

3. Covered Entity shall notify Business Associates of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR

*164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

4. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity. Nothing in this paragraph shall restrict the ability of Business Associate to use or disclose PHI as set forth in paragraph C.2. Herein.

E. Remedies in Event of Breach.

Business Associate hereby recognizes that irreparable harm will result to Covered Entity, and to the business of Covered Entity, in the event of breach by Business Associates of any of the covenants and assurances contained in Paragraphs B or C of this agreement. As such, in the event of breach of any of the covenants and assurances contained in Paragraphs B or C above, Covered Entity shall be entitled to enjoin and restrain Business Associate from any continued violation of Paragraphs B or C. Furthermore, in the event of breach of Paragraphs B or C by Business Associate, Covered Entity shall be entitled to reimbursement and indemnification from Business Associate for the Covered Entity's reasonable attorney's fees and expenses and cost that were reasonably incurred as a proximate result of the Business Associate's breach. The remedies contained in this Paragraph E shall be in addition to (and not supersede) any action for damages and/or other remedy Principal may have for breach of any part of this Agreement.

F. Term and Termination

1. Term of Agreement. The Term of this Agreement shall be effective as of the date given at the top of Page 1 herein, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is in-feasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.
2. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - a. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Cover Entity;

- b. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
- c. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

3. Effect of Termination.

- a. Except as provided in paragraph E.3(b) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
- b. In the event that Business Associate determines that returning or destroying the Protected Health Information is in-feasible, Business Associate shall provided to Covered Entity notification of the conditions that make return or destruction in-feasible. Upon notification to Cover Entity that return or destruction of Protected Health Information is in-feasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make return or destruction in-feasible, for so long as Business Associate maintains such Protected Health Information.

G. Miscellaneous Terms

- 1. State Law. If state law applicable to the relationship between Business Associate and Covered Entity contains additional or more stringent requirements than federal law for Business Associate regarding any aspect of PHI privacy, then Business Associate agrees to comply with the higher standard contained in applicable state law.
- 2. Consideration. Business Associate recognizes that the promises it has made in this Agreement shall, henceforth, be detrimentally relied upon by Cover Entity in choosing to continue or commence a business relationship with Business Associates.
- 3. Modification. This Agreement may only be modified through a writing signed by the Parties and, thus, no oral modification hereof shall be permitted. The Parties agree to take such action as is

necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, as amended.

4. Notice to Covered Entity. Any notice required under this Agreement to be given Covered Entity shall be made in writing to:

5. Notice to Business Associate. Any notice required under this Agreement to be given Business Associate shall be made in writing to:

IN WITNESS WHEREOF and acknowledging acceptance and agreement of the foregoing, the Parties affix their signatures hereto.

COVERED ENTITY

Officer

Dated: _____, 20 _____.

BUSINESS ASSOCIATE

Officer

Dated: _____, 20 _____.

