Kent K. Morikado, DDS, PC
General Dentistry for the Family

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医療におけるプライバシー保護

森門歯科医院では医療におけるプライバシー(個人情報)保護の法令、HIPAA (Health Insurance Portability and Accountability Act)、に基づき「医療情報プライバシー保護ガイドライン」を作成し診療及び事務処理を行っています。ガイドラインは、当院内に掲示しておりますがコピーをご希望の方は受付にお申し出ください。

HIPAA Patient Consent Formは、この法令に関する患者様の同意書です。

ご署名の上、受付にご提出下さい。予約案内のメッセージはご指定頂いた電話番号（自宅、勤務先、携帯等）に残させていただきます。

又、患者様のご予約、治療費/治療内容、保険、お支払方法等のご相談をご家族の方やご勤務先担当者に依頼される場合はYour Protected Health Information Designees に代理人氏名及び患者様との関係（配偶者、友人、勤務先人事担当者等）をご記入下さい。

なお、当院と患者様以外(医療機関・保険会社を除く)とのコミュニケーションを一切禁じる場合は該当欄にイニシャルをご記入下さい。

本件に関し、ご質問等ございましたら担当のChikakoまでお気軽にお問い合わせ下さい。

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HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment, and health care operations.

I have been informed by you of your *Notice of Privacy Practice* of the uses and disclosures of my health information, and of my right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that the office of KENT K. MORIKADO, DDS, PC has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact Chikako McLean, Office Manager, at any time at the address above 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that your organization will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them and obtain copies with written request. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law. Images that identify me will be released and/or used outside the office only upon written authorization from my legal representative or myself.

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HIPAA Confidential Communication Authorization

Confidential Voice Mail:
Please check below where we have your permission to leave a confidential voice mail (e.g. appointments, emergency communication, prescription information, etc.). Leave the space(s) blank if you do not wish to receive voice mails.

Home Phone ☐ Work Phone ☐ Cell Phone ☐ Other Phone ☐

Email ☐ _____

Your Protected Health Information Designees:
If you are not available at the time that we call, please list below those individuals (designees) with whom we can leave a message or briefly discuss your dental appointments, insurance information, and treatment related information (e.g. prescription information).

This person (designee) will also be able to call the office on your behalf.

Please print the name(s) and relationship to you/patient of each designee below:

Designee Name	Relationship to Patient

_____ Please initial here if you **do not want** your health care information discussed with anyone other than yourself, other health care providers and insurance company personnel.

Patient Name:_____
(Please print)

Signature:_____ Date: _____
(Parent's signature, if the patient is a minor)