Alisa You Yeon Lee, DDS
Lee Dental of Arlington Heights

637 E. Golf Road, Suite 205
Arlington Heights, Illinois 60005
Telephone: 847-593-6480

医療におけるプライバシー保護

リー・デンタルクリニックでは医療におけるプライバシー保護の法令、HIPAA (Health Insurance Portability and Accountability Act) に基づき「医療個人情報保護の指針」を作成し診療及び事務処理を行っております。当指針（ガイドライン）のコピーをご希望の方は受付までお申し出下さい。

HIPAA Patient Consent Form （裏面）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。予約のご案内メッセージは、ご指定の電話番号に残させて頂きます。

又、患者様のご予約、治療費、治療内容、保険、お支払い方法等のご相談を、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 の欄に代理人指名及び患者様とのご関係（配偶所、勤務先担当者、等）をご記入下さい。

当院の患者様以外（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望まれない場合は該当欄にイニシャルをご記入下さい。

本件に関するご質問等は担当の Diana までお気軽にお問合せ下さい。

リー・デンタルクリニック

Alisa You Yeon Lee, DDS
Lee Dental of Arlington Heights

637 E. Golf Road, Suite 205
Arlington Heights, Illinois 60005
Telephone: 847-593-6480

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 ALISA YOU YEON LEE, DDS, has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact Diana Kim, 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, x-rays, 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. I consent to images/x-rays to be used for promotional and/or educational purposes. 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.

* * * * *

HIPAA Confidential Communication Authorization

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

Home Phone ☐ Work Phone ☐ Mobile 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)