



Southport Dental Care

10690 South Federal Highway • Suite A
Port Saint Lucie, FL 34952
1 (772) 335-3300

Dear Valued Patients,

Our staff of health care providers at Southport Dental Care are committed to maintaining the privacy we believe our patients richly deserve. Recent federal legislature mandates that health care providers comply with the Health Insurance Portability & Accountability Act of 1996, referred to as "HIPAA".

Our office already complies with most aspects of HIPAA; however, we do need a family permission slip to continue our notification practices. Please be aware, we are not changing the way we notify you, we are merely asking that you acknowledge our existing office policy. Below you will find a list of our notification practices. Please take time to read them before you sign.

Permission for the following:

- Submit your insurance claims electronically
- Leave a message on your voicemail or machine regarding appointments
- Leave a verbal message with another family member regarding your appointment
- Contact your insurance company, if warranted
- Mail a reminder postcard through the USPS
- Treat your minor children & discuss treatment with parents and or guardians
- Allow interoffice communication concerning your dental care
- Allow staff to discuss pertinent treatment with referring Doctors
- Discuss your case, by name, with our dental labs via telephone or mail to ensure accuracy and quality of work
- Other times your name might be used in the day to day normal operations of a dental practice

We hope you understand that we are trying to comply with Federal Government regulations. In the future, the practices may change. If so our office will notify you.

Very truly yours,

Dr. Michael Cook, DMD

Southport Dental Care will not use any of our protected health information (PHI), including names, social security number, phone number, or financial information, in any way that is not connected with the proper dental treatment of your family.

You will be signing below agreeing that you have read and understand the HIPAA notification policy. My signature grants permission for Dr. ~~Michael Cook~~ DMD to do the best of their reasonable ability to treat your family and understand your right to privacy.

Patient signature

Date