Dr. Soto Dentist - Downey
8018 Stewart and Gray Rd, Downey, CA 90241 | (562) 923-7799

HIPAA Privacy Notice & Consent Form

Notice of Privacy Practices - Acknowledgment

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

Dr. Soto Dentist is committed to protecting your personal health information. We are required by law to maintain the privacy of your protected health information (PHI), provide you with notice of our legal duties and privacy practices, and notify you following a breach of unsecured PHI.

How We May Use and Disclose Your Information

Treatment: We may use your health information to provide dental care and coordinate treatment with other healthcare providers.

Payment: We may use and disclose your health information to bill and collect payment for services. This may include contacting your insurance company.

Healthcare Operations: We may use your information to improve the quality of care, train staff, and conduct business planning.

Appointment Reminders: We may contact you to remind you of scheduled appointments via phone, text, email, or mail.

As Required by Law: We will disclose health information when required by federal, state, or local law.

Your Rights

• Request restrictions on how your health information is used or disclosed

• Request confidential communications (e.g., contact at a different phone number)

• Inspect and obtain a copy of your health records

• Request amendments to your health information

• Receive an accounting of disclosures of your health information

• Receive a paper copy of this notice upon request

Contact Information

If you have questions about this notice or wish to exercise your rights, please contact our office: Dr. Soto Dentist, 8018 Stewart and Gray Rd, Downey, CA 90241. Phone: (562) 923-7799.

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have received and reviewed a copy of Dr. Soto Dentist's Notice of Privacy Practices. I understand that I may request a copy of this notice at any time.

Patient Name (Print): **Date of Birth:** _____

_____

Patient/Guardian Signature: **Date:** _____

_____

For Office Use Only:
If patient unable or unwilling to sign:
Reason: _____