PRODENTAL
FAMILY DENTISTRY

Disclosure Authorization and Mutual Agreement to Maintain Privacy

Patient Name(please print) _____

Dr. Beliy and ProDental Dentistry (collectively labeled "Dentist") agree to maintain the privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy that is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, HIPAA forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted information. Dentist believes this is improper and may not be in the patient's best interest.
Accordingly, Dentist agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Dentist; and will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentist's practice.

Dentist feels strongly about Patient's privacy as well as the practice's right to control its public image and privacy. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs, or other electronic, print, or broadcast media without prior written consent.

Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to Patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

X _____ _____
signature of patient, parent, or guardian **date**

Val Beliy D.M.D. /ProDental Dentistry

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Notice of Information Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

Any member of my immediate family ___yes ___no
Spouse ___yes ___no
Other _____ ___yes ___no

X _____ _____
signature of patient, parent, or guardian **date**