PATIENT CONSENT FORM
HIPAA

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal health/dental care operations such as quality assessments and doctor certifications.

I have been informed by you of your Notice of Privacy Act Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Act Practices prior to signing this consent. I understand that this office has the right to change these practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Act 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 health/dental care options. I also understand that you are not required to agree to my requested restrictions, but if you do agree you are bound 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 if I choose to deny this consent, I am responsible for any charges not paid by insurance due to this action.

Patient Name: _____

Signature: _____

Relationship: _____

Date: _____

I wish to allow access to the following individual(s):

(This is so that we may provide information to spouses, parents of adult children, caregivers, etc.)

Please indicate: ☐ Account/Payment Access ☐ Dental Records/Appointment Access

Name of Person(s): _____