



PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ◆ Treatment (including direct and indirect by other healthcare providers involved in my treatment);
- ◆ Obtaining payment from third party payers (e.g. my insurance company);
- ◆ The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these restricted restrictions. However, if you do agree, you are the bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

In addition, by signing, I authorize communication from your office via email or text message regarding my dental treatment.

Signed this _____ day of _____ 20_____

Printed Patient Name: _____

Signature of Patient or Guardian: _____

Relationship of Patient: _____

For Office Use Only:

Our office made a good faith effort to obtain a signed HIPAA Consent Form,
but it could not be obtained for the reason(s) listed below.

Date: _____ Witness: _____

Reason Specified: _____

