HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have a right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive. Copy of Privacy Policies supplied by request.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we discuss your dental condition with any member of your family? YES NO

If yes, please name the person(s) allowed:

_____

_____

This consent was signed by _____

(Print name please)

Signature_____ Date_____