HIPAA Consent Form

Please tell us with whom we are allowed to discuss and/or disclose your person health information by circling all that apply:

Myself Only **Spouse** **Parents** **Sibling(s)**

Adult Children **Personal Representative** **Employer**

<u>Please print name(s) of above:</u>

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My signature below authorizes the release of dental/medical information to any specialist I may be referred to and to process insurance claims and prescriptions.

I understand that under the HIPAA act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the dental providers who may be involved in the treatment directly or indirectly.
- Obtain payment from third-party payers.

I have received, read, and understood your Notice of Privacy Practice containing a more complete descriptions of the uses and disclosures of my health information. I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment or payment.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

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Patient/Responsible Party Name

____ _________________

Patient/Responsible Party Signature **Date:**