Requirement of New Regulations for the HIPAA (Privacy Act)
Effective April 2013

I understand that I have certain rights regarding my protected health information. These rights were 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:

I. Treatment; including direct or indirect treatment by other healthcare providers involved in my treatment.
II. Obtaining payment from third party payers. (ex. the insurance company)
III. The day-to-day healthcare operations of this practice.

I have also been informed of, and given the right to review and secure a copy of the Notices of Policy Practices, which contains a more complete description of the uses and disclosure of the uses and disclosures of the patient's protected health information and rights under HIPAA.

I understand that the office may reserve the right to change the terms of this notice from time-to-time and that the patient may contact the office anytime to obtain the most current copy of this notice.

I understand that the patient has the right to request restrictions on how their protected health information is used and disclosed to carry out treatment, payment, and health care options, but the office is not required to agree to these restrictions; however if the office does agree, they are bound to comply with this restriction.

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

Please list anyone that pertinent dental information may be shared with:

_____ _____

_____ _____

_____ _____

Patient Name: _____

Patient Signature: _____

Date: _____