Notice of HIPAA Regulations and Consent Form

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or dental care operations.

By signing this form, you consent to our use and disclosure of protected dental information about your treatment, payment and dental care operations. You have the right to revoke this consent, in writing signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. This office provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient/ parent or guardian understands:

Protected health information may be disclosed or used in treatment, payment, or dental care operations.

Patient has an opportunity to review Notice of Privacy Practices

Patient has the right to restrict the uses of their information.

Patient may revoke this consent in writing at any time and all future disclosures will cease.

This office may condition receipt of treatment upon execution of this consent.

Please list below authorized people to access records

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Name: _____

Patient /Parent or Guardian Signature: _____

Date: _____/_____/_____Relationship to Patient: _____