HIPPA PATIENT CONSENT FORM

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

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

Obtaining payment from third party payers (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 if you're Notice of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information and my right under HIPPA. 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 healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

Patient Preference Regarding Communication of Health Information

I hereby give permission to Dr. Adriana Clark, DDS and Staff, to disclose and discuss any information related to my medical /dental condition with the following member. Name:_____
Relationship:_____

I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

I have received a copy of the Material Fact Sheet and was given the option to take a copy home or recycle it back to the office.

Print Patients
Name_____Signature_____

Date: _____