

Patient Consent Form

I understand that I have certain rights 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 and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (eg. My insurance company)
- The day to day operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights 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 health care 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 or disclosures that occurred prior to the date I revoke consent is not affected.

PATIENT CONSENT FOR RELEASE OF MEDICAL/DENTAL RECORDS

I understand that previous dental or medical conditions and/or treatment received should be considered by my dentist as such may relate to my present dental condition, diagnosis, and potential treatment options. Therefore, I hereby authorize and consent to my dentist obtaining copies of my medical and dental records from current or past dentists, physicians, psychologists or hospitals, or any other medical/dental care provide to release copies of my records to my dentist upon request. I authorize any health care provider who has treated me to discuss the care and treatment rendered to me with my dentist. This authorization shall be valid until withdrawn by me, in writing.

Whom else may we discuss your treatment with:

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____