**Family and Cosmetic Dentistry**

**HIPAA & PRIVACY POLICY 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 (HIPAA). 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 (e.g. 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 of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my right under HIPAA.

**Notice of Privacy Practices**

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations at our dental clinic.

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
* The Practice reserves the right to change the Notice of Privacy Practices.
* The patient has the right to restrict the use of their information but the Practice does not have to agree to the restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition receipt of treatment upon the execution of this Consent.

Signed this Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_