

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.

Note: We will not share your opt-in to an SMS campaign with any third party for purposes unrelated to providing you with the services of that campaign. We may share your personal data, including your SMS opt in or consent status, with third parties that help us provide our messaging services, including but not limited to platform providers, phone companies, and any other vendors who assist us in the delivery of text messages. All of the above categories exclude text messaging originator opt in data and consent; this information will not be shared with any third parties.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____