HIPAA Consent

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

Patient First Name: _____ Patient Last Name: _____ DOB: _____ ☐ Initial Acknowledgement of Privacy Practices

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to protected health information that we maintain.

Authorization to Disclose Protected Health Information

I hereby authorize Willow Family Dentistry, to disclose my protected health information to health care providers and the following below:

Names, Phone Numbers & Relationship for Authorization of individuals (If none: N/A):

Description of Information to be disclosed:

The information to be disclosed includes: Treatment History Full Dental Records (All documents, notes & x-rays requested) Billing & Account information

Checkboxes

☐ I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:

Sign

Signature and Acknowledgement

I hereby acknowledge that I have read and understand the contents of this authorization form. I consent to the release of my dental health information as described above in accordance with the provisions of HIPAA. I understand that I may ask for clarification of this authorization or additional information if necessary.

Signature

Sign

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____