Patrick R. Person, D.D.S.

HIPAA 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 dental treatment)

-Duties involved in obtaining payment from third party payers (e.g. insurance company)

-The day to day operations of the dental practice including:

- Confirming appointments by phone, postcard, email or text message.
- Leaving messages regarding pending appointments by voicemail / answer machine.
- Leaving messages regarding medications or pre-medications that might be needed for an appointment.
- Leaving messages regarding appointments or medications needed with members of the patient's household.

I understand that I am financially responsible for the entire bill if insurance claims are rejected. 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 HIPAA. 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 car operations, but that you are not required to agree to these requested restrictions. However, if you so 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 disclosure that occurs prior to the date I revoke this consent is not affected.

Signed this _____day of _____. 20____

Print Patient's Name_____ Relationship_____

Signature_____