HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. Dentistry West provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosure or used for treatment, payment or health care operations
- Dentistry West has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The patient has the right to restrict the use of their information, but Dentistry West does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Dentistry West may condition treatment upon execution of the Consent

Below is a list of ways the office could contact you. Please check all that apply. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office.

Cell_____ Home_____

Email _____ Work _____

List name of who can have access to your medical information/What parts of the chart are they allowed access?

_____ Full access/Partial access_____

Patient Name: _____

*Signature of Patient or Legal Guardian_____ Date_____

(Patients 18 and over must complete this form)

Patient refuses to sign - Staff and one witness - sign below:

Staff Signature _____Date _____

Witness Signature _____Date _____