HIPAA Privacy Acknowledgment & Authorization Form

HIPAA Privacy Acknowledgment

First Name - Patient *

Last Name - Patient *

- 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 { office name} to use and disclose protected health information in order 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 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 care operations, but that you are not required to agree to these requested restrictions. However, if you do 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 occurred prior to the date I revoke this consent is not affected.
- I understand and acknowledge my rights as detailed in the Notice of Privacy Practices presented here.
- I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned in the Authorization form presented to me in a separate document

Authorization to Discuss Dental Information

Due to HIPPA privacy regulation, we can not release information about your dental care to anyone without your permission.

Please list any family members, guardians, caregivers, or other individuals with whom we may discuss your dental treatment, appointments, billing, or insurance information.

If you do NOT authorize anyone to to receive information about your dental care please list "none" under name column.

Name: *	Relationship: *

I certify that I have read and understand the information above.

Signature *

Clear

Date *