HIPAA Consent and Release

Acknowledgement of Receipt of Notice of Privacy Practices

The HIPAA Rule for Privacy establishes standards that address the use and disclosure of an individual's health information, referred to as "protected health information," that is created, stored and exchanged by Covered Entities (Covered Entities include health care providers, health plans, and health care clearinghouses), and to provide a standard for health care providers to carry out treatment, payment and health care operations.

As our patient, it is important that you know we respect the privacy of your personal dental records, and we strive to secure, protect, and take reasonable precautions to protect your privacy. When it is appropriate and necessary we provide the minimum required information to only those we feel are in need of your health care information. We may also provide information about your treatment, payment or health care operations, in order to provide health care that is in your best interest. We may have indirect treatment relationships involved in your care (such as laboratories that only interact with doctors and not patients), and we may have to disclose personal health information for purposes of treatment, payment, or health care operations. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing to our office. Under the privacy law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you agree to the consent and release of this document, at some future time you may request or refuse all or part of your personal health information. You may not, however, revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our Notice of Privacy Practices before you decide whether to sign this consent and release form. This Notice includes important matters about your protected health information. We reserve the right to change our privacy practices as described in this Notice. If a changed occurs, we will issue a revised Notice of Privacy Practices containing any amendments, which may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions, at anytime by contacting our office with the request.

Release of Information

In addition to the necessary release of information as stated above, I authorize the release of information including diagnoses, records (written and images), financial status, and appointment information to:

- ○ _____Relationship_____
- ○ _____ Relationship_____
- ○ _____Relationship_____
- ○ Not Applicable

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

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____