HIPPA PATIENT CONSENT FORM

I understand that I have a right to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information for:

- 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 of Privacy Practices, which contains a more complete description of the uses and disclosure of my protected health information and my right under HIPPA. 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 healthcare 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 of disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Preference Regarding Communication of Health Information

Who to contact:

I hereby give permission to Bay Area Dental Office and Staff, to disclose and discuss any information related to my medical/dental condition(s) with the following family member(s), relative(s), and/or close personal friend(s).

Name ___________________________ Relationship ___________________________

☐ I do NOT wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical/dental condition(s).

Print Patient's Name ______________________________________

Signature ______________________ Date: __________________