HIPPA Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our notice of privacy practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk.

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 my treatment).

The day to day healthcare operations of your practice.

I have also been informed of, and given the rights to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the use 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 request restrictions.

However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.

The Patient understands that:

We will not release information to any future doctor, attorney, life insurance Company, or workman's company without your written consent.

Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with **your insurance company**, or healthcare operations within our office.

Sweet Tooth Dental Center reserves the right to change the notice of privacy practices.

The patient has the right to restrict the use of their information, ***Sweet Tooth Dental Center*** does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.

The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice of ***Sweet Tooth Dental Center*** may condition treatment upon the execution of this consent (for example, you may be required to pay your visit at the time of service)

Signed this _____ day of _____ 20_____

Relationship to Patient_____

Signature_____