PATIENT HIPAA CONSENT FORM

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 Dr. Henna Hussain and the staff at Friendly Family Dental 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);
• 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 disclosures of my protected health information and my rights under HIPAA. I understand that Friendly Family Dental reserve the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

In addition, I authorize the following person/people access to my dental records on my behalf:

□ check here if I grant no additional person access to my dental records.

Name:_____ Relationship: _____
Name:_____ Relationship: _____

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.

Date Received and Signed: _____

Print Patient/Parent's Name _____

Patient/Parent's Signature _____

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