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HIPAA Patient Consent Form and Release Authorization

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

*****You may discuss treatment and financial arrangements with: _____

_____

RELEASE Authorization:
I hereby authorize the release of my dental records with respect to any dental care and treatment that may be requested to be transferred. I release EGR dental from all legal responsibility or legal ability that may arise from release of such information. A reproduced copy of this authorization shall be valid as the original

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

___Individual refused to sign
___Communication barriers prohibited obtaining the acknowledgement
___An emergency situation prevented us from obtaining acknowledgement
___Other – please specify_____

Contact Information:

I authorize EGR Dental to contact me via telephone, email, text and/or postal mail in providing appointment reminders and healthcare information. Signature below represents acknowledgement of this information

Patient name: _____ Date:_____

Signature: _____

Relationship to patient (if a minor) _____