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**Health Insurance Portability and Accountability Act Form  
(HIPAA)**

Our notice of Privacy Practices provides information about how we may use and disclose health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this consent.

By signing this HIPAA form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus rule provide you this information with your knowledge and consent.

This consent signed by: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient(if other then the patient): \_\_\_\_\_

In front of: \_\_\_\_\_

May we please have a current email address for electronic communications and or a cell phone # if you prefer text msgs. This information will not be shared.

Email: \_\_\_\_\_ Cell: \_\_\_\_\_

Is there a friend/family member who we may share personal/dental information with if needed?

Name \_\_\_\_\_ Contact info \_\_\_\_\_