HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information.

The notice contains a patient's rights section describing your rights under the law. By signing below, you acknowledge that you have reviewed our notice prior to signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. While we are not required to agree to restrictions, we will honor them when possible.

By signing this form, you consent to our use and disclosure of your protected healthcare information as described above.

Please indicate your preferences below:

May we phone, email, or text you to confirm appointments? YES NO

May we leave a message on your answering machine or cell phone? YES NO

May we discuss your dental conditions with a family member? YES NO

If YES, please list authorized family members:

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Patient Name (Print): ______________________________

Signature: __________________________ **Date:** ____________