FAMILY DENTISTRY

DR. MILES NEFF, DDS

HIPAA Consent Form

Consent for Use and Disclosure of Person Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, Please contact:

Office Manager at (425) 252-0111 or 3230 Colby Ave. Suite #3 Everett, WA 98201

Patient's Consent

Name: _____

Address: _____ Social Security Number: _____

City: _____ State: _____ Zip: _____

Telephone: (_____)_____ E-mail: _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Signature: _____ Date: _____

If this consent is signed by a parent on behalf of the patient, complete the following:

Parent or Guardian's Name: _____

Relationship to Patient: _____

Patient's Revocation (only sign if you want to revoke HIPAA)

By signing below, you revoke you above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ Date: _____

If this consent revocation is signed by a parent on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____