

HIPPA 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. I understand that by signing this consent I authorize you 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 HIPPA rights. I understand that you reserve the right to change the terms of this notice and that I may contact you to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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.

Signed this _____ day of _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

Due to changes in Federal Law we must now ask you to specify any individual with whom we may discuss your medical/dental history, labs, x-rays, medications, etc.

I hereby authorize Snow and Snow, PC, to disclose any/all information in relation to my dental care to:

- _____ Relationship _____
- _____ Relationship _____
- _____ Relationship _____