Consent for Use and Disclosure of Health Information and Release Form

H.I.P.A.A. Certified

PATIENT INFORMATION

Patient's Name______________________ DOB____/____/______

Address ______________________ City____________ State____ Zip_____

Home Phone (_____)________________ Work Phone (_____)______________

Cell Phone (_____)________________ Email ____________________

Our Practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 H.I.P.A.A. *(Health Insurance Portability and Accountability Act), under the Department of Health and Human Services* requirements to include the September 2013 *"Omnibus"* updated Privacy regulations. Our Practice Privacy policies, in accordance, allows us to use your personal information for "Normal and Customary" services when required communication within the Healthcare profession, both clinical and administrative to include but not limited to: Consultations with another Healthcare professional such as your medical doctor or another dental specialist about your treatment or progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

☐ **Request For Exemption(s)** – Mark this box if you wish for any of your information **NOT** to be used for normal and customary practices within the Healthcare Profession. Specifically write your request for exemption(s) or limitation(s) below. *Example: No calls to work phone.*

**Practice Use Only: Exemption(s) Declined, Patient Informed. Signature/Date:*__________________

Who May We Release Information to: – Please specify anyone you authorize our Practice to release information and what type of information we may give out, if requested and approved, about you, your treatment, progress or account. Usually this is a spouse or significant other, Parent or Guardian, Grandparents, adult children or whomever you choose to authorize our Practice and our Healthcare Associates to release information to.

PLEASE PRINT COMPLETE NAME(s) AND LEGAL RELATIONSHIP TO PATIENT.

____

Complete Name Relationship Date

Type of Information authorized to release:

☐ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

☐ *Treatment / Condition* ☐ *Financial / Administration*

____

Complete Name Relationship Date

Type of Information authorized to release:

☐ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

☐ *Treatment / Condition* ☐ *Financial / Administration*

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Complete Name Relationship Date

Type of Information authorized to release:

☐ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

☐ *Treatment / Condition* ☐ *Financial / Administration*

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Complete Name Relationship Date

Type of Information authorized to release:

☐ **NO RESTRICTIONS FOR THIS INDIVIDUAL**

☐ *Treatment / Condition* ☐ *Financial / Administration*

I have read, reviewed and considered the contents of this Consent form and was given a copy of the Practice's "Notice of Privacy Practices". I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependants *(Minor Child or other person(s) whom I am the legal guardian of)* protected Private personal and health information in any form deemed needed in the Practice's professional judgment and in accordance with our normal and customary Privacy and Security practices. You have the legal right to amend or revoke this Consent given at any time by providing us written notice.

____

Signature (Adult) Date

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other *(Specify)*

____

Signature (Adult) Date

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Other *(Specify)*