Complete Family Dental
Patient HIPAA 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 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment
- Obtaining payment from third party payers
- The day-to-day health-care 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 rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time 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 health care 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 these restrictions. 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_____.

Printed Patient Name_____

Signature_____

Relationship to Patient if Minor (Under 18)_____

(Optional) I authorize these individuals below to obtain any information regarding my treatment plan, x-rays, and finances ahead of time if needed for any reason. With this authorization, this stays on file and does not change unless I request so myself.

1._____Relationship_____

2._____Relationship_____

3._____Relationship_____