ASCENT DENTAL GROUP HIPPA CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance 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 (including direct or indirect treatment by other healthcare providers involved in my treatment)
Obtaining payment information from third party payers (i.e. insurance company)
The day-to-day healthcare operations of this 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 used and disclosures of my protected health information, and my rights under HIPPA. I understand 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 healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with 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 revoked this consent is not in effect.

Print Patient Name:_____

Patient Signature:_____ Date:_____

Relationship to Patient:_____

Number(s) May we leave a message on:

_____

_____

With whom may we leave a message?

_____

Is Email Direct? May we e-mail regarding treatment?

(YES) (NO) Email:_____