CREVE COEUR

FAMILY & SEDATION DENTISTRY

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information (PHI). 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 PHI to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payer (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 PHI 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 PHI 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 this restriction. I understand that any requests made on my part are to be made in writing. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Creve Coeur Family and Sedation Dentistry to release my PHI to the following individual(s) should the need arise:
_____

I authorize the following PHI to be shared with the above-mentioned individual(s): _____ X-Rays _____ Diagnosis/Treatment _____ Appts _____ Account/Insurance Info

I authorize Creve Coeur Family and Sedation Dentistry to leave any PHI via: _____ Voicemail _____ Text Message _____ Email _____ Please communicate with me directly

I have had full opportunity to read and consider the contents of this consent form. I understand by signing this form, I am giving my consent for your use and disclosure of my PHI to carry out treatment, payment activities and healthcare options.

Patient Name: _____ Patient Signature: _____ Date: _____

If someone is filling out this HIPAA Consent on behalf of the patient, please fill out the following:

Name/Relationship: _____

Signature: _____ Date: _____