Consent for Use and Disclosure of Health Information and Release Form

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 HIPPA (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 and progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

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 dependant's (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 judgement and in accordance with your normal and customary privacy and security practices.

I have the legal right to amend or revoke this Consent given at any time by providing your practice with a written and signed notice.

Our practice retains the right to decline treatment should you choose not to sign this Consent, should you choose to revoke it, or should you have what we would consider unreasonable exemptions.

_____ _____
Signature Date

_____ _____
Signature of personal representative Date

_____
Please print name of representative

☐ Request for Exemption: 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 / mark your request for exemption(s) or limitation(s) below. Specify the person(s) you do not want your information released to.

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