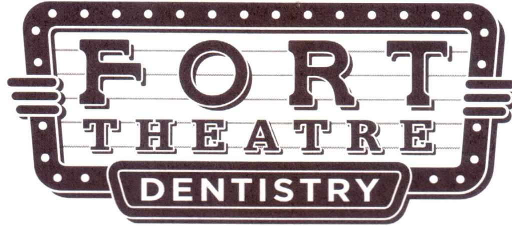
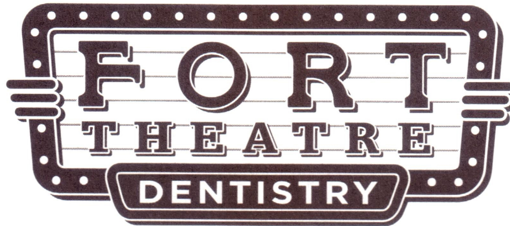


EXPLANATION OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Effective April 14, 2003 Federal Regulations required healthcare providers not to give any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parents, other household members, relatives, etc.; even when they call or come in to our office on your behalf or at your request, **unless you have given us permission to speak with them**. I acknowledge that I have been offered a copy of the HIPAA law. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Account Services.

This authorization does not expire. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. I understand that Fort Theatre Dentistry has the right to change the Notice of Privacy Practices from time to time, and I may at any time contact them for a current copy.



Patient Consent Form for Care & Treatment
And HIPPA Authorization and Notification

By signing this authorization, I understand that my information will be disclosed for the following:

- I give consent for any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment for my or my dependent.
- For general healthcare operations
- Appointment reminders and individuals involved in your care, including nurse calls
- This authorization also gives permission to leave messages on answering machines.

I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examinations rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Only the persons involved with my direct care are allowed access to my account information and/or medical condition(s) and treatment.

If I am unable to act on my own behalf, you may speak with the following person(s):

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

Name: ______________________ Relationship to Patient: ______________________

**A release of records, signed by the patient, is necessary for medical records documents.*

______________________________ ______________________

Signature of Patient or Legal Representative | Relationship to Patient

______________________________ ______________________

Patient Name (Please Print) | Patient Date of Birth

____

Date Signed