HIPAA CONSENT FORM

Date: ___________________

Patient name: ____________________

Patient Phone Number that we may leave a secure message on: ________________________

HIPAA-Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Brookside Family Dentistry may use or disclose your health care information. The Notice also explains the right that you are guaranteed under HIPAA regulations. Though Brookside Family Dentistry has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice of Privacy Practice.

I hereby acknowledge that I have received a copy of Brookside Family Dentistry Notice of Privacy Practices.

Initials of patient/guardian_____

PERMISSION TO SHARE DENTAL INFORMATON

I authorize any medical/dental information to share with my insurance company and/or any medical professional.

Initials of patient/ guardian_____

My Dental information may be obtained and exchanged with the following:

Name______________________________ Relationship___________________________

Name______________________________ Relationship___________________________