PATIENT HIPAA CONSENT FORM

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

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Continuity of care.
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of our practice.
- Electronic Communications used for appointment notifications, patient communications, practice promotion and any requested information on your behalf.

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 protected health information 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 protected health information 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.
Please list any person(s) you would like involved in your care or payment for your care.

_____ _____

_____ _____

This consent will continue forever unless I cancel it by writing to: ***Whitewater Family Dentistry, 1515 West Main St, Whitewater, WI 53190*** *if the consent is cancelled, it will not change releases that have already been made prior to the date of cancellation.*

If you prefer to have your HIPAA consent to expire, please set an expiration date. I would like my consent to expire on: _____.

Signed this _____day of _____20____.

Print Patient Name_____

Signature_____

Relationship to Patient_____