HIPPA Consent Form

Our notice of privacy practices provides information about how we may use and protect health information about you. The notice contains a “Patient Rights” section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting either of our offices.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payments, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I authorize that either office may contact me in the following manner. (Check all that apply):

(_) Home Phone (_) Cell Phone (_) Work Phone (_) Email

Please list the name(s) of people whom we may disclose information about you to:

Name: ____

Name: ____

I have received a copy of North Aiken Dental’s HIPPA policy:

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Signature of Patient or Parent/Guardian Date