HIPAA Dental Form

PATIENT INFORMATION

Name: _____ **Date of birth:** _____ dd / mm / yyyy

Phone number: _____ **Email address:** _____

Address: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), this form is used to obtain your consent for accessing and disclosing your protected health information (PHI). We are required to inform you about your rights concerning your information and the privacy practices of our dental practice. By signing this form, you consent to the collection, use, and disclosure of your PHI for treatment, payment, and healthcare operations as outlined in our Notice of Privacy Practices. This includes consent to access your patient information when necessary for treatment or administrative purposes.

PURPOSE OF USE AND DISCLOSURE OF PATIENT INFORMATION

Treatment: Your PHI may be used to provide dental treatment or services, including sharing information with specialists or other healthcare providers involved in your care. Payment: Your PHI may be used to process insurance claims, billing, or other payment-related activities. Healthcare operations: We may use or disclose your PHI for healthcare operations, such as quality assessments, audits, or training. Access to patient information: Your PHI will be accessed and shared by authorized personnel within our practice as necessary for treatment, administrative purposes, and healthcare operations, all in compliance with HIPAA regulations.

PERSONAL REPRESENTATIVE INFORMATION

If you are unable to make healthcare decisions for yourself, the following person is authorized to make decisions on your behalf:

Name of personal representative: _____ **Relationship to patient:** _____

Contact information: _____

SCOPE OF AUTHORITY

This section grants the personal representative authority to access patient information, provide consent for treatment, and make decisions related to the disclosure of PHI on your behalf.

PATIENT RIGHTS

Inspect and copy your PHI. Request amendments to your PHI if you believe it is incorrect or incomplete. Request restrictions on how your PHI is used or disclosed. Request confidential communications (for example, to be contacted at a different address). For more details on your rights, please refer to the Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have received and reviewed the dental practice's Notice of Privacy Practices, which explains how my PHI will be used and disclosed. I consent to the use and disclosure of my PHI, including the access of my patient information, for treatment, payment, and healthcare operations as required by HIPAA. I also consent to the disclosure of my PHI to the person(s) listed as my personal representative (if applicable).

Patient signature:

Date: _____ dd / mm / yyyy

IF SIGNED BY PERSONAL REPRESENTATIVE

Signature of personal representative:

Relationship to patient: _____ Date: _____ dd / mm / yyyy

HIPAA ACKNOWLEDGMENT

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and have had the opportunity to ask questions regarding my rights and the privacy practices of this dental practice.

Patient signature:

Date: _____ dd / mm / yyyy