HIPAA Consent Form

GENERAL INFORMATION

Name

Date of Birth

Street Address

City

State

Zip

HIPAA PRIVACY RIGHTS & INFORMATION DISCLOSURE *Please read the following statements carefully.*

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Downtown Dental's Notice of Privacy Practices, updated effective January 1, 2023.

Under the requirements for HIPAA, your information will be used to:

- Provide and coordinate my treatment among several health care providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third-party payers for my health care services.

If you wish to have your dental condition and/or dental treatment disclosed to someone else, please provide the below information.

AUTHORIZATION OF PHI DISCLOSURE

Please select below:

- ◯ I AUTHORIZE Downtown Dental to disclose my information to the following recipients:
- ◯ I DO NOT AUTHORIZE Downtown Dental to disclose my information to the following recipients:

Name of Person #1

Relationship to You

Purpose of Disclosure

Name of Person #2

Relationship to You

Purpose of disclosure

SIGNATURE

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

☐ I have had full opportunity to read and consider the contents of this Consent & Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian

Date