CENTRAL DENTAL ASSOCIATES

HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers.
3) Conduct normal health care operations such as quality assessments and physicians certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I also understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print): _____

Relationship to patient: _____

Signature: _____ Date: _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____Date of Birth: _____

*written communication: Address to: _____

_____

If the address provided is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment.

*oral communication: Home #: _____

Email: _____

Work#: _____

Cell#: _____

*Oral communications Call: May we leave a message that you need pre-medication? Yes _____ NO _____

May we leave a message when you have a dental appointment? Yes _____ NO _____

****** Office Use Only ******

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices but was unable to do so as documented below.

Date: _____ Reason: _____ Initials: _____

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