Consent for Use and Disclosure of Health Information

In our efforts to comply with the Health Information Privacy Practice Act, HIPPA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please Check Your Response to the Following:

May we leave detailed messages concerning your appointment/treatment with a co-worker, receptionist or secretary that regularly answers your calls? ☐ Yes ☐ No ☐ N/A

May we leave detailed messages on a voicemail at work? ☐ Yes ☐ No ☐ N/A

May we leave detailed messages on an answering machine at home? ☐ Yes ☐ No ☐ N/A

Please list family/friends below that we may discuss your appointments/treatment with:

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Name: ____ Relationship: ___________________

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this consent form and your notice to 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 healthcare operations:

____ ____________________

Signature of patient, Guardian of patient or Parents Authorized Representative Date

Relation to Patient ____

____ ____________________

Witness, Authorized Representative of Piedmont Dentistry Date