



### HIPAA COMPLIANCE CONSENT FORM

The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the use of the information for treatment, payment, or healthcare operations. Our *Notice of Privacy Practices* provides a complete description of this information and is available to read in its entirety upon request. We reserve the right to change the terms of this notice and you may contact us to obtain the most current copy. By signing this form, you consent to our use and disclosure of your protected health information. You have the right to revoke this consent in writing, however a revocation will not be retroactive.

I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payors (e.g. my insurance company)
- Day to day healthcare operations of the practice

In addition, many of our patients allow family members or others to call and request dental or billing information.

Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have this information released to anyone, you must give written authorization. Signing this form will only give authorization to persons indicated below.

I give my consent for Wayne & Julie Scott DDS to release my medical and/or billing & account information to the following individuals:

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**None**

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_