**Fort Family Dental Patient HIPAA Consent Form**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. 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 part payers (e.g. my insurance company)
* The day-to-day healthcare operations of Fort Family Dental.

I have also been informed and given to right to review and secure of copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you ay any time to obtain the most current copy of this notice.

I understand the I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, by that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

BY DEFAULT, I AUTHORIZE ANYONE LISTED UNDER MY FORT FAMILY DENTAL ACCOUNT TO HAVE ACCESS TO MY PRIVATE HEALTHCARE INFORMATION, INVOLVEMENT IN MY CARE AND PAYMENT FOR MY CARE.

Please list any **additional** individuals you would like to have access to your protected health information:

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Please list any individuals from your account you would like to **restrict** access to your protected health information:

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Signature of Patient of Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_