John R. Strief, D.D.S.

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PATIENT PRIVACY CONSENT FORM

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. (PHI)

I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its policy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the policy.

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 healthcare operations also understand that you are not required to agree to my requested restrictions, but if you do, you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have already acted and released information, relying on my original authorization.

Patient Name: _____

Signature of Patient: _____

Relationship to Patient: _____SELF _____PARENT (If patient is under 18) _____ OTHER _____

Date: ___ / ___ / ___