HIPAA CONSENT FORM

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you acknowledge receipt of North Shore Dental LLC Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice has the right to disclose information if they deem it absolutely necessary. For example in an emergency situation.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Below is a list of ways the office could contact you. Please check all that apply. Checking a box will give permission to leave, as thorough of a message as needed, from your dental office.

__ Personal Cell _____ __ Home Phone _____

__ Email _____ __ Work Phone _____

__ Fax _____ __ Emergency Contact _____

__ Mail to Home __ Any of the above

List names of who can have access to your medical information / What parts of the chart are they allowed access? Full access allows us to disclose all information regarding your care at our office. Partial access allows us to disclose limited information, determined by the patient.

Name _____ __ Full access
Number _____ __ Partial access (select from the following options)
Relationship _____ __ Appointments __ Billing/Insurance __ Treatment

Name _____ __ Full access
Number _____ __ Partial access (select from the following options)
Relationship _____ __ Appointments __ Billing/Insurance __ Treatment

Print Patient's Name _____

Signature of Patient or Legal Guardian _____ Date _____
(Patients 18 and over must complete this form)

If patient refuses to sign, notate:
Date provided to patient: _____ Reason for refusal: _____
Staff Signature _____ Date _____