HIPAA Consent Form *Oral Surgery of Tidewater*

Ford & Guter, D.D.S, Ltd.

Our Notice of Privacy Practices 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. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. 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 health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you 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 uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent.

Below is a list of ways the office may contact you. Checking a box will give us permission to leave, as thorough of a message as needed, from your dental office. This will include, but not be limited to, appointment day, time, and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any source other than USPS, example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check all that apply, and write in appropriate information needed for contact.

____Personal Cell____ ____Home Phone__________________________________

___Work Email____ ___Personal Email_______________________________

___Mail to Work____ ____Mail to Home________________________________

____Emergency Contact__________________________________ ___Other____

List the names of those who may have access to your dental/medical chart information: State what part of your chart: Financial, Treatment and/or Health History, is allowed to be disclosed or copied

____________________________Full Access/Partial Access ________________________________Full Access/Partial Access

Post operative care escort if different from above:____ Number:______________________________

Oral Surgery of Tidewater

_____Patient gives office permission to forward any verified contact information and PHI (Protected Health Information) to patient's specialists. Office may discuss pertinent chart information, including PHI, with labs, and product representatives involved in patient's case through verified unsecured, unencrypted means. Under HIPAA regulations, healthcare providers do not need permission for Public Policy Purposes, refer to Notice of Privacy Practice. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Example: Dental Labs. Patient understands if permission is not granted, USPS (Federally Secured) is the only means of communication with those involved in patient's case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment cost. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name ____ **Date**___________________________

Print Legal Guardian's Name____ **Date**__________________________

Signature of Patient or Legal Guardian____ **Date**__________________________

______Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Witness: _______________________________ Printed Name____ Date__________________________