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 of 1996 (HIPAA). 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 payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a 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 at any time to obtain the most current copy of this notice.

I understand that 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, but 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 the office may charge me $35.00 should I fail to keep my appointment or fail to provide the office with 24 hours advance notification of cancellation.

I consent to receive emails, calls and text messages from Northshore Metropolitan Dental Associates for my protected healthcare and other services at the email address and phone number(s) on file, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I authorize disclosure of my dental and medical information to the following family members: _____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 2020

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Northshore Metropolitan
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