

The Office of
Harry J. Tsotsos, D.M.D.
Health Insurance Portability & Accountability Act of 1996 (HIPAA)
CONSENT FOR USE AND DISCLOSURE OF DENTAL INFORMATION

Section A: PATIENT INFORMATION

Name: _____

Section B: FOR PATIENTS WITH INSURANCE ONLY

I, (The above Patient), gives Consent to contact my Insurance Carrier in regard to treatment/eligibility in this office.

Section C: GIVING CONSENT

I, (The above Patient), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected dental information to carry out treatment, payment activities and dental care operations.

Signature of Patient: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

(If Patient is a Minor)

Personal Representative's

Signature: _____ **Date:** _____

Relationship to Patient: _____

Section D: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected dental information to carry out treatment, payment activities, and dental care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and dental care operations, of the uses and disclosures we may make of your protected dental information, and of other important matters about your protected dental information. A copy of our Notice is available at the front desk. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notices of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes will also be posted. Those changes may apply to any of your protected dental information that we maintain. You may maintain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time at the front desk or by contacting our office manager.

Right to Revoke: You have the right to revoke this Consent at any time by sending written notice of your revocation to the office manager. Please understand that the revocation of this Consent will not affect any action we have taken in reliance of this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke this Consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT, UPON REQUEST.