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 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 _____ 20_____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

If you do not agree with our HIPPA consent please check the box.

☐ **I REVOKE MY** Consent for your use and disclosure of my protected health information for treatment payment activities and healthcare operations. I understand that you may decline to treat me after I have revoked my consent.

I (patient/guardian)_____, grant permission to my dental provider to discuss the protected health information of (patient name) _____ with the following.

Name _____ Relationship_____

Phone_____ Email or Mailing Address_____

I may revoke my permission at anytime verbally and it must be confirmed in writing.

Practice Name: Michael D. Wasco DDS
Address: 987 C East Cherry St
City/State/Zip: Canal Fulton OH, 44614