HIPAA Consent Form

Patient name ____

Patient phone number ____

HIPAA

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how our office may use or disclose your health case information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA compliance officer: Mary Barrett.

I hereby acknowledge that I have received a copy of Closurdo Family Dentistry's Notice of Privacy Practices.

Signature ____ Relationship __________________________________

Permission to share medical information

My medical information may be obtained and exchanged verbally to __________________________________

Signature ____ Relationship __________________________________

Permission to bill your insurance

☐ I understand my signature authorizes Closurdo Family Dentistry to release my information to my insurance company for payment under my dental insurance plan.

☐ I do not have dental insurance and understand I will be responsible for the balance on my account.

Signature ____ Relationship __________________________________