HIPAA CONSENT FORM

Date:

Last Name: First Name: Birthdate:

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);
- Obtain payment from third party payers (e.g. my insurance company);
- Carry out the day-to-day healthcare operations of J Rivas Dental practice.

I have had the full opportunity to read and consider the contents of the Notice of Privacy Practices. I also understand that I have the right to revoke permission. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Patient or Legal Guardian

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual decline to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify):