

Health Insurance Portability and Accountability Act Consent Form

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception room for patients to review. Please sign this as your acknowledgement that this office is following HIPPA policy. By signing this form, you consent to our use and disclosure of your protected health information to carryout treatment, payment activities, and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

Please initial the following statements:

- _____ Potected information may be disclosed or used for treatment, payment, or healthcare operations.
- _____The practice has a Notice of Privacy Practices & that I have the opportunity to review that notice.
- _____The practice reserves the right to change the Notice of Privacy Policies.
- _____Patients have the right to restrict the uses of their information,
but the practice does not have to agree to those restrictions.
- _____The patient may revoke this consent in writing at any time & all future disclosures will then cease.
- _____The practice may condition treatment based on the execution of this consent.

In order to insure the accuracy of your protected health information, it is our office policy to update this form annually. I authorize Dr. Chillemi to release my dental or insurance information as necessary to process my dental claims and coordinate or manage my dental care. In the event a family member or caregiver attends my dental visit and is in the exam room at the time of my evaluation or treatment, I give Dr. Chillemi and staff members my permission to discuss freely, my condition, treatment, or diagnosis with that person. **Yes / No**

	May we call your name out loud in our lobby?	Yes / No
Home Phone: (____) _____	May we leave a message?	Yes / No
Work Phone: (____) _____	May we leave a message?	Yes / No
Cell Phone: (____) _____	May we leave a message?	Yes / No
Email Address: _____	May we leave a message?	Yes / No

With whom may we discuss financial issues relating to treatment & diagnosis? _____

Printed Name of Patient: _____

Date: _____ Signature: _____

Relationship to patient: _____