PRAST FAMILY DENTAL
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 to 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 request that all communications to me regarding appointments to be handled in the following manner:

E-Mail Reminders? (Please list email)_____
Text Reminders? (Please list phone number)_____
May we leave a message on an answering machine? _____
May we leave a message with a family member? _____
May we call you at work?_____ Phone Number_____

I give permission for the practice to discuss my treatment and/or financial information with: my spouse_____ parent/guardian _____ other (name)_____

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 on 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.

Date _____

Print Patient Name _____

Signature of Patient or Representative _____

Relationship to patient (if other than patient)_____

Witness (Practice Representative)_____

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Occasionally our office will post information / photos on social media for fun, interactive games, contests, informational items, etc. If you feel that you would or would not like to participate, please let us know by signing this form. You may revoke permission in writing at any time. Your image will never be used without your consent.

I consent that Prast Family Dental may use images of me/my child (photographs or videos) on their social media tools including but not limited to their Facebook page. I understand that these images/videos will not be used for any other commercial purpose.

I give consent to use my/my child's images

Yes _____

No _____

Form will expire in 5 years from signature unless requested otherwise.

Date _____

Print Name _____

Signature of Patient or Representative _____

Relationship to patient (if other than patient) _____

Witness (Practice Representative) _____