Port Warwick
DENTAL ARTS
COMPREHENSIVE DENTISTRY FOR TOTAL WELLNESS, FUNCTION AND BEAUTY

HIPPA Consent Form

From the office of : Dr Lisa Marie Samaha/Port Warwick Dental Arts

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under law. You have the right to review our notice before signing this consent by requesting a copy from the receptionist. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

By signing this form, **you consent to our use and disclosure of Protected Health Information about you for treatment, payment and healthcare operations.** You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

· Protected health information (PHI), may be disclosed or used for treatment, payment or Healthcare operations
· The practice has a Notice of Privacy Practice and the patient has the opportunity to review this notice
· The practice reserves the right to change the Notice of Privacy Practices
· The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions
· The patient may revoke this consent in writing at anytime and all future disclosure will then cease
· The practice may condition treatment upon execution of this Consent

Below is a list of ways the office may contact you. **Checking a box will give permission to leave a confidential message from our dental office.** This will include, but is not limited to appointment day, time and treatment scheduled, documents to be signed, financial and collection concerns or pre and post treatment directions. Any Source other than USPS, for example: cell phones, email and fax lines, are not considered 100% secure. Contact information will be verified by patient.

Please check any options that you DO NOT want the office to contact. We will be using the numbers/emails you have updated on your account information. All information is subject to availability to verify and validate.

_____ WORK PHONE _____ WORK EMAIL _____ MAIL TO HOME _____ EMERGENCY CONTACT
_____ PERSONAL CELL _____ HOME PHONE _____ HOME EMAIL _____ INTERPRETER CONTACT _____ ANY OF THE ABOVE

List the names of who can have access to your Dental/Medical chart information: circle type

____FULL Access / PARTIAL Access

____FULL Access / PARTIAL Access

State what part of your chart is allowed to be disclosed or copied

Financial FULL Access / PARTIAL Access **Treatment** FULL Access / PARTIAL Access

Health FULL Access / PARTIAL Access

Patient gives the office permission to forward any verified contact information and PHI to patient's specialists. Office may discuss pertinent patient chart information, including PHI, with labs and product representatives involved in patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other healthcare providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnosis, and Medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers including providers who are not covered entities, to treat a different patient, or to refer the patient. See form 45 CFR 164. 506. Any Source, other than your Healthcare Providers, will sign a business associate agreement. Patient understands if permission is not granted, USPS is the only means of communication with those involved in patient's case, and is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick-up copies of PHI to be hand-delivered.

PWDA will occasionally send out information and invitations for sponsored events including but not limited to concerts, lectures etc. Would you like to be included on this list? ___yes ___no

Print Patient's Name ___________________________________ Print Legal Guardian's Name _________________________________

Signature of Patient/Legal Guardian ____Date ______________________

________ **patient refused to sign HIPAA consent. USPS or patient pickup will be used for PHI transfer.**
Initials

Office Staff Signature ________________________________ Printed Name _______________________________Date______________

Witnessed Staff Signature ________________________________Printed Name ___________________________Date______________

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