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HIPAA COMMUNICATION CONSENT FORM

I authorize the doctors and staff of Prostho. Endo. Dental Specialists may leave messages on my voicemail/text messages to confirm appointments, and/or may speak with other members of my household to leave messages with them regarding my appointments via mail, email, home phone, office phone, cell phone numbers.

Please initial for acknowledgement: _____

I hereby authorize that the doctors and staff of Prostho. Endo. Dental Specialists may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

I hereby authorize that the doctors and staff of Prostho. Endo. Dental Specialists may disclose my personal health information to the person who I have listed as my emergency contact.

I understand that Prostho. Endo. Dental Specialists is a teaching facility. The doctors may use my radiographs and clinical images for teaching purposes (i.e. lectures, social medial, case presentations). No patient identifiers will be visible.

I understand that at any time I have the right to revoke this consent or request to know how my protected health information is being used or disclosed to carry out treatment, payment, and healthcare operations.

I understand that any such request of my patient record must be provided by me to the practice in writing.

By my signature below, I affirm the above information.

Patient Signature: _____Date: _____

Signature of Guardian/Authorized Representative: _____

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NOTICE OF PRIVACY PRACTICES

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

I authorize the following individuals (example: spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you do not list anyone, we WILL NOT share any information regarding your account.

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize, that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

Patient Signature: _____Date: _____

Signature of Guardian/Authorized Representative: _____