CONSENT TO USE & DISCLOSE YOUR HEALTH INFORMATION (HIPAA)

Name -- Phone (   ) ---

Address -- City/State -------------------------------------- Zip -----------------------

When I examine, diagnose, treat or refer you, I collect what laws call Protected Health Information (PHI) about you. This is essentially the information that is kept in your chart or medical record and/or may include clinical notes, diagnostic information, personal demographics & authorized communications with other healthcare professionals. PHI is used to decide what treatment is appropriate as well as document your treatment. Upon your authorization, PHI may be shared with other individuals such as your dental specialist & for payment for services provided to you. There are certain other situations in which your PHI may be released, such as a court order by a judge, workers compensation claims, or in legally mandated reporting situations such as child abuse or instance of threatened self harm or harm to others. In order to protect your privacy to the greatest extent possible, it is our practice in this office to keep only the minimal necessary information in your clinical record.

By signing this consent form, you agree to the use of your information in this office with respect to keeping this information as a part of a treatment record & with respect to sharing this information with others as described above. If you do not sign this consent for, I cannot maintain a clinical record, bill for services to you, or communicate with other healthcare providers & therefore, cannot treat you. This consent form is provided to you in order that our office may comply with the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

If you are concerned about some of your information, you have the right to ask that I not use or start some of your information for treatment, payment or administrative purposes. If you have special requests with regard to your PHI, you will have to submit the request in writing. Although, in most cases, I will make attempts to respect your wishes, I am not required by law to agree to such limitation. In some instance, because of the demands of the law I may be unable to comply with your wishes. In the future these policies may change. If they do, the change will be detailed in our Notice of Privacy Practice. The complete HIPAA notice can be reviewed in this office or a printout can be given at your request.

After you have signed this consent, you have the right to revoke it. Under the law however, it will be necessary to do so in writing. This revocation will be applied to future uses of disclosures of your PHI but will have no effect on information disclosed in conjunction with your evaluation and/or treatment prior to the date of the revocation.

Signature of Patient or Legal Guardian/Representative **Date**

Printed name of Patient or Legal Guardian/Representative

Signature of Witness **Date**