

PATIENT CONSENT FORM

Patient's Name: _____

Address: _____ City _____

CA, Zip _____ Phone () _____

Privacy Officer (PO): _____ Office Contact Person (OCP): _____

- Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your Protected Health Information (PHI);
You have the right to review our *Notice of Privacy Practice Practices* before signing this *Patient Consent Form*. Please take the time to do so now. A copy is attached.
You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Dental Office Operations. Request for *Restriction of PHI* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;
 - Our office does not have to agree with your *Request of Restriction of PHI*. If we agree to your request to your *Request of Restriction of PHI*, we shall honor the agreement.**You have the right to** revoke this *Patient Consent Form*. Revocation of *Consent* must be submitted to the OCP in writing and signed by you as specified in our *Notice*;
 - A *Revocation of Consent*, does not affect disclosures made prior to the date the *Revocation* was made.
- Our *Notice of Privacy Practice* may change from time-to-time. If it does, you will receive a "revised" *Notice* on the first visit after changes to the *Notice* were made.
- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during Treatment, Billing/Payment, and Dental Office Operations as outlined in our *Notice*.
- Our office may condition dental treatment upon execution of this *Patient Consent Form*.
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This Patient Consent was signed by: _____ (Print Name of Patient or Representative) _____ (Relationship to Patient)

Patient's Signature Date

Witnessed by: _____ (Print Name of Privacy Officer or Office Contact Person) _____ (Title)

Signature Date