

West Chester Dental Group

HIPAA Patient 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 the doctors and staff of West Chester Dental Group to use and disclose my protected health information to carry out:

- Treatment (Including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (i.e. my insurance company); the day to day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of our 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 the office reserves the right to change the terms of this notice from time to time and that patients may contact us 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, and health care operations, but that West Chester Dental Group is not required to agree to these requested restrictions. However, if doctors and staff do agree in writing, then they are 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.

Signed this date: _____

Print Patient's Name: _____

Relationship to Patient: _____

Signature: _____