PERFECT SMILES
FAMILY DENTISTRY

PATIENT CONSENT FORM

Patient's Name: _____

Address: _____ City _____

CA, Zip _____ Phone ( ) _____ FAX ( ) _____

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 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 for Restriction of PHI*. If we agree to your *Request for Restriction of PHI,* we shall honor that 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 Practices* 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 (HIPAA).

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**

White to Patient Chart Canary to Patient

H:\HIPAA Forms\Patient Consent Form.doc created 4/1/03
X 10200