Littleton Implants & PERIODONTICS

PATIENT CONSENT FORM (HIPAA)

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 am authorizing you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice
- Methods of payment, including credit card information (although encrypted) will be kept safe and protected.

I have also been informed of, and given the right to review and secure a copy of your *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 you reserve the right to change the terms of this notice from time to time and that I may contact you 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 you are not required to agree to these requested restrictions. However, if you do agree, you are then 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 ____ day of _____, 2019

Print Patient Name: _____

Relationship to Patient (if signing for a minor) _____

Signature: _____

Documentation of Good Faith Efforts to obtain patient's acknowledgment that they received provider's Notice of Privacy Practices
(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office and was provided a copy of covered entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of this notice. However, such acknowledgment was not obtained because: ☐ Patient refused to sign, ☐ Patient was unable to sign because: _____ _____ ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity ☐ Other reason: _____

Signature of employee completing form: _____ Date:_____