Perfect Smiles Dental
FAMILY & COSMETIC DENTAL CARE

HIPAA PATIENT CONSENT FORM

In April 2003, new federal requirements regarding privacy of information for health care patients take effect HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Perfect Smiles Dental requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Many of our patients allow family members such as their *spouse, parents* or *others* to call and request the results of tests and procedures. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to a family member you must authorize and sign this form. Signing this form will give consent to release laboratory and radiology (x-rays) results, discuss treatment plans and options, discuss insurance co-payments and account balances with this individual indicated below.

You have the right to revoke this consent, in writing, except where we have already obtained prior consent (see "Release".)

I authorize Perfect Smiles Dental to release laboratory and radiology (x-rays) results, discuss treatment plans and options, discuss insurance co-payments and account balance with the following individuals via phone or email communications if previously authorized.

☐ **Authorize** ☐ **Not Authorized**

1. ______________________________ Relationship to Patient: __________________ Date _________
2. ______________________________ Relationship to Patient: __________________ Date _________

Authorization to Leave Messages with Answering Machines and Provided Email

From time to time it is necessary for representatives of Perfect Smiles Dental to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of Perfect Smiles Dental discuss your medical circumstances or conditions without your consent. The purpose of this consent is to leave messages with members of your household, on your answering machine, or through a provided email address, including family email accounts, per authorization.

You have the right to revoke this consent in writing, except where we have already obtained prior consent (see "Release".)

I authorize Perfect Smiles Dental to contact me at home and leave messages on answering services and with family members to confirm, schedule or re-schedule appointments.

☐ **Authorize** ☐ **Not Authorized**

Print Patient Name _________________________ Print Guardian's Name______________________
Patient/Guardian's Signature (if under 18) _________________________________ Date____________