J. Robert Foote, Jr. DMD
Commonwealth Dental, PSC

HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Commonwealth Dental, PSC 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. insurance company)

* Day-to-day healthcare operations of the practice (phone calls / email / text reminders / confirmations of appointments via online service)

I have also been informed of, and given the right to review 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 Commonwealth Dental, PSC reserves 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 healthcare operations, but you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent in writing, at any time. Until such time, this consent will remain in effect indefinitely. However, any use or disclosure that occurred prior to the date I revoke this consent, is not affected.

Signed this _____day of _____, 20 _____.

Patient Name Printed: _____

Signature: _____

Relationship to Patient: _____