NEW HAVEN DENTAL

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (HIPAA)

I understand that as part of my healthcare, New Haven Dental originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as:

A basis for planning my care and treatment.
A means of communication among the many healthcare professionals who contribute to my care.
A source of information for applying my diagnosis and surgical information to my bill.
A means by which a third-party can verify that services billed were actually provided.
A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that New Haven Dental is not required to agree to the restrictions requested.
To inspect and copy your health records as required by law.
To revoke this consent in writing, except to the extent that New Haven Dental has already taken action.

_____

May we discuss the patient's medical/dental condition with members of your family, or friends, who may contact the office regarding the patient? _____ Yes _____ No

If yes, please list below the name of that person and their relationship to the patient.

Name of Person	**Relationship to Patient**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give the staff permission to release information (verbal or written) regarding the dental condition of and/or information regarding treatment to the above names persons(s) for the purpose of dental care.

PATIENT NAME (Print)_____ BIRTHDATE_____

SIGNATURE: _____ DATE:_____

11/30/2020