Jackson County Dental
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Seymour, IN 47274

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Patient Consent Form

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

- Treatment (including direct or indirect treatment by other health care providers involved in my treatment);
- Obtaining payment from third party payer (i.e. my insurance company).
- Health care operations necessary to run the business aspect of our practice (i.e. quality assessment, auditing functions and customer service).

I have also been informed of and given the right to review and secure a copy of you 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, in writing, restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care options, but that you are not required to agree to these requested restriction. 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.

Date

Print Patient Name:

Relationship to Patient:

I give my permission to release information about this patient to the following people:

Response Date: