HIPAA CONSENT FORM

(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1995)

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 1995 (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 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.**

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contain a more complete description of the uses and disclosures of my protected health information, and my right 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 use and disclosed to carry out treatment, payment, and healthcare 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 of disclosures that occurred prior to that date I revoke this consent is not affected.

Patient Name_________________________ **Parent or Legal Guardian Name** _________________________

Patient or Legal Guardian Signature_________________________ **Date:** ____________

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NOTICE OF DEEMED CONSENT TO HIV, HEPATITIS B, HEPATITIS C

BLOOD TESTING

A Virginia law was enacted in 1989 that allows health care providers to test their patients for HIV antibodies, Hepatitis B, and Hepatitis C when a health care worker is exposed to the blood or bodily fluids of a patient which may transmit human immunodeficiency virus (HIV) the virus which caused AIDS or Hepatitis B.

Because this is a law, in the event of such exposure, you will be deemed to have consented to such testing and to have consented to the release of test results to the exposed worker.

Except in emergencies, you will be informed before any of your blood is tested for HIV antibodies, Hepatitis B, and Hepatitis C, and testing will be explained to you. You will be given the opportunity to ask any questions you may have.

You will be provided with the test results and appropriate counseling. Test results, if positive, are required by law to be reported to the Virginia Department of Health.

I certify that I have read and fully understand that this consent will remain in effect as long as my dependent or I receive care from Kenneth Stoner DDS dental practices.

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Patient Name **Parent or Legal Guardian Name**

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Patient or Legal Guardian Signature **DATE**