HIPPA PRIVACY CONSENT FORM
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
And authorization to Contact

ROBERTSON FAMILY DENTISTRY
10139 Royalton Rd., Suite E
North Royalton, OH 44133

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers whom may be involved in that treatment directly and indirectly
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT AUTHORIZATION TO CONTACT

[ ] I authorize this office the Release of Information including the diagnosis, records, examination rendered to me and claims information.

[ ] Information is not to be released to anyone

Information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____

[ ] Please leave me a message asking to return your call

The Release of Information will remain in effect until terminated by me in writing. This authorization is only for the employees of Robert Family Dentistry to use as long as I am a patient.

Patient Name _____

Relationship to Patient _____

Signature _____ **Date** _____