HIPPA CONSENT FORM

Patient Name: ____

HIPPA – Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how The Tooth Doctor may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though the Tooth Doctor has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of privacy Practice.

I hereby acknowledge that I have received a copy of The Tooth Doctors Notice of Privacy Practices.

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Initials of patient/guardian

Permission to Share Medical Information

My Medical Information may be obtained and exchanged verbally to:

____
Name/Relationship

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Initials of patient/guardian