HIPPA Consent

I give the dental practice of Dr. Eric N. Bloom my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been provided a copy of and read Dr. Bloom's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Dr. Bloom's office has the right to change their privacy practices and that I may obtain any revised notices at the office.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Dr. Bloom's office is not required to agree to the request. If the office agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

If signed by patient representative: Patient's Name: _____

Relationship to Patient: _____

FINANCIAL Consent

I authorize use of the following signature for all insurance submissions. I understand however that I am responsible for any and all financial charges incurred at Dr. Bloom's office.

Signature: _____
Patient, Parent or Legal Guardian

If signed by patient representative: Patient's Name: _____

Relationship to Patient: _____