



HIPAA CONSENT

Patient's Name: _____ Birthdate: ____/____/____

I give Edwards & Smith Family Dentistry 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 informed that I may review Edwards & Smith Family Dentistry Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I have been offered a copy of Edwards & Smith Family Dentistry Notice of Privacy (please check applicable box).

Received copy of notice

Declined copy of notice

I understand that Edwards & Smith Family Dentistry has the right to change their privacy practices and that I may obtain any revised notices at Edwards & Smith Family Dentistry.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Edwards & Smith Family Dentistry is not required to agree to the request unless the disclosure is to a third party payor, such as Medicare, Medicaid, or a private insurer. If Edwards & Smith Family Dentistry agrees to any other 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.

I HEREBY AUTHORIZE Edwards & Smith Family Dentistry to disclose any and all information regarding my treatment and health to the following people:

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

The above list is comprised of persons who may inquire about my health for my benefit and to possibly pass this information on to me. As such, I understand this information is being disclosed pursuant to my request and hereby hold harmless Edwards & Smith Family Dentistry for any redisclosure by any such person listed above. I understand that I have the right to inspect the disclosed information at any time.

I ACKNOWLEDGE THAT I MAY REQUEST A COPY OF THIS DOCUMENT

AUTHORIZED PERSON'S SIGNATURE

____/____/____
DATE