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PATIENT HIPAA CONSENT FORM

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 1996 (HIPPA). I understand that by signing this consent I authorize Greater Boston Dental to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g. my insurance company):
3. The day to day healthcare operations of the practice.
4. Obtaining further records from my medical doctor if it determined that my medical condition is having an impact on my dental health.
5. Submitting insurance claims to my medical insurance carrier if appropriate; I also hereby authorize any and all payments from my medical insurance to be paid to Mark Strokowski DMD.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPAA. I understand that you reserve the right to change the terms of this notice from time to time an 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 used and disclosed to carry out treatment, payment and health care operations, but that Greater Boston Dental is not required to agree to these requested restrictions. However, if Greater Boston Dental does agree, then it is bound to comply with these restrictions.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred proper to the date I revoke this consent is not affected

Print Patient Name_____

Date_____

Signature_____