H. Rush Smith D.M.D.
Cosmetic & Restorative Dentristy
204 McFarland Circle North
Tuscaloosa, AL 35406

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 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment):**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day to day healthcare operation of your practice.**

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 HIPAA. I understand that you reserve the right to change the terms of this notice from time to time 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 healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

ADA Guide for Compliance with "The New Red Flags Rule for Protection of Identify Theft and Detection Response Program" are in place.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent in not affected.

Print Patient Name _____

Signature: _____

Please list the Name and Relationship of person(s) with permission other than parent/legal guardian to accompany patient to appointments. The person(s) listed can make decisions about treatment administered at this visit or any future visits, can also make changes to appointments and will be responsible for any co-payment due at the time of the appointment.

Name/Relationship _____ Date _____

Office Personnel _____ Date _____