PRAIRIE PLAINS DENTAL
PATRICK J. CAPP, DDS

HIPPA COMPLIENCE CONSENT FORM

Our Notice of Privacy provides information about how we may use or disclose protected health information. This notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing the consent. The terms of this notice may change, if so, you will be notified at your next visit to updated you signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or health operations. We do not require agreeing with the restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) laws allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected health care information and potentially anonymous usage in publication. You have to right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protecting the health information may be disclosed or used for treatment, payment or health care operations.
- The practice reserves the rights to change the privacy policy as allowed by the law.
- The patient has the right to restrict the use of the information but the practice does not have to agree with the restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- We can release and/or receive protected health information (dental records, x-rays, medical records) as needed.
- We can phone, email or send a text to you to confirm appointments.
- We can leave a message on your answering machine at home or on your cell phone.
- We can discuss your medication with immediate family members regarding your dental needs.

Signature:_____Date:_____

If you would like to add a family member, care giver to be able to access or discuss your medical information please print & sign name below.

I authorize _____(name of person you want to add) to access my Protected Health information under the HIPPA Privacy Rule for the purposes of coordinating care.