Trophy Smiles

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HIPAA PATIENT CONSENT FORM

As you may be aware, a new federal law went into effect on April 14, 2003. The Health Insurance Portability and Accountability Act (HIPAA) require Dr. Arthur Reynolds, Jr., PLLC to provide you with its Notice of Privacy Practices. It outlines your privacy rights as a patient.

We may use information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family:
Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. Health Professionals may discuss Protected Health Information (PHI) with parent of minor (under age of 18 or in school and covered by parent's insurance policy) unless specifically instructed not to do so.

Worker's Compensation or Disability Insurance:
We may disclose health information to extent authorized by the extent necessary to comply with laws relating to workers compensations or other similar programs established by law.

Public Health:
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

For the patient's review and signature:

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that this information and will be used to: *Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in the treatment directly and indirectly.

- ***Obtain payment from third party payers.**
- ***Conduct normal healthcare operations, such as quality assessments and physician's certifications.**

I have been informed by you and your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right the change it's Notice of Privacy Practices from time to time and that I may contact this organization at any time or come to our office to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that restrict how my private information is used or disclosed to carry out treatment, payment on health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke the consent in writing at any time, except to the extent that you have action relying on this consent.

Patient Name (please print): _____

Signature: _____

Relationship to Patient: _____