HIPPA

Patient Name:_____________________________ **Date**:_____________

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 you to use and disclose my protected health information to carry out:

- Treatment (including direct or 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 operations 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 HIPPA. 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 being used and disclosed to carry out treatment, payment, and health care 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.

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 is not affected.

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

This information may be released to:

- **Spouse**___________________________
- **Child(ren)**_________________________
- **Other**____________________________
- **Information is not to be released to anyone.**

This Release of Information will remain in effect until terminated by me in writing.

Print Patient Name:____

Relationship to Patient:____________________________________

Signature:____

Woodbine Dental

901 DeHirsch Ave
Woodbine, NJ 08270
(609) 861-2784

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of my dependents or myself. My signature on this document authorizes my dentist to electronically submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for my dependents and/or myself. This signature will bind me as though personally signing any particular claim. I authorize the doctor to perform work on my dependents and myself. I am the person responsible for payment to the doctor for the procedures on my dependents and myself.

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Date

____

Print

____

Signature