RAH
D.D.S. P.A.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices Provides information about how we may use or disclose protected health information. The notice contains a patients' rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

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

By signing this from you consent to our use and disclosure of your protected healthcare information and potentially antonymous usage in publication. You have the right to revoke this contest in writing, signed by you. However, such a revocation will not be retroactive.

By Signing this form, understand that:

- Protected Health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice (R. Asher Henegar DDS PA) reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree with those restrictions.
- The patent has the right to revoke this consent in writing at any time and all full disclosures will them cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call, email, or text to confirm appointments? Yes No

May we leave a message on your answering the machine at home or cell? Yes No

May we discuss your medical or dental conditions with any of your family? Yes No

If Yes please List the family member here_____

_____

Signature Date