

Florissant Dental Care
HIPAA CONSENT FORM



Date: _____

Patient name: _____

Patient Phone Number that we may leave a secure message on: _____

HIPAA-Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information.

The purpose of the Notice of Privacy Practice is to explain how Belleville Dental Care may use or disclose your health care information. The notice also explains the right that you are guaranteed under HIPAA regulations. Through Belleville Dental Care has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPPA Privacy Rule to distribute the notice of privacy Practice.

I hereby acknowledge that I have received a copy of Belleville Dental Care Notice of Privacy Practices.

Initials of patient/guardian _____

PERMISSION TO SHARE DENTAL INFORMATON

I authorize any medical/dental information to share with my insurance company and/ or any medical professional.

Initials of patient/ guardian _____

My Dental information may be obtained and exchanged with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____
