GUTTORMSEN & HOFFNER DENTAL

HIPAA CONSENT FORM

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

AND CONSENT/LIMITED AUTHORIZED AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER DOCTOR/FACILITIES IN THE FUTURE.

_____ _____

Please **PRINT** name of Patient Please **SIGN** for Patient/Legal Guardian

_____ _____

Representative/Guardian Relationship to Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, HEALTH, AND/OR BILLING INFORMATION VIA:

Home Phone _____ Text Message _____

Work Phone _____ Email _____

Cell Phone _____ Any of the Above _____

Signature: _____ Date: _____