ZORA FAMILY DENTAL

HIPAA

PATIENT/FAMILY CONSENT FORM

I understand that I/We have certain rights to privacy regarding my/our protected health information. These rights are given under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I/We understand that by signing this consent I/We authorize Zora Family Dental to use and disclose my/our 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 operation of Zora Family Dental

I/We have also been informed of, and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my/our protected health information, and my rights under HIPAA. I/We understand that you reserve the right to change the terms of this notice from time to time and the I/We may contact you at any time to obtain the most current copy of this notice.

I/We understand that I/We have the right to request restrictions on how my protected health information is used to disclose 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/We understand that I/We may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I/We revoke this consent is not affected.

Patient/Family
Name(s):_____
_____
_____
_____
_____

Signature:_____

Relationship to patient:_____