OAK PARK DENTAL

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HIPAA AUTHORIZATION

I understand that, under the Health Insurance Probability & Accountability Act of 1996 (HIPAA). I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

(Patient Name) _____

(Relationship to Patient) _____

(Signature) _____ (Date) _____

(Optional) I give my permission for this office to discuss my medical/dental/financial information with the following person(s).

_____ Relationship _____

_____ Relationship _____

CONFIRMATION PERMISSION

Our office does like to confirm your appointment prior to the scheduled appointment. We may occasionally need to leave a message on your answering machine or leave a message with a family member for you to call our office.

It is okay for your office to leave a message at my home.

(Signature of Responsible Party) _____ (Date) _____