HIPAA- Consent Form for Patients

James M. Blake, D.D.S

Acknowledgement of Receipt of Notice of Privacy Policies
And Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities* and healthcare operations of the office as described in the Notice.

Name of Patient _____
(*If you are over 18 but your parents are responsible for your bill, this also includes permission allowing us to share your information with them.)
I consent to share treatment & financial information with the following:

Spouse: _____

Parents: _____

_____

Legal Guardian: _____

Children (ie. Senior parent): _____

Other: _____

Signature of the Patient or Personal Representative

Print Name of Patient or Personal Representative (including description of legal authority/ relationship to patient)

_____

Date: _____