# PRIVACY HEALTH INFORMATION CONSENT

HIPAA Privacy allows you the right to restrict use and disclosure of your Personal Health Information. You are allowed the right to request confidential communication using alternative means such as correspondence. By signing this form, you consent to our use and disclosure of your protected health information to carry our treatment payment activities and other healthcare operations.

Please tell us how we may contact you and to whom we may disclose your health or account information.

**Home Phone** (  )_____-_____  **Work Phone** (  )_____-_____

**Cell Phone** (  )_____-_____  **Alternate Phone** (  )_____-_____

_____You may **ONLY** leave information with me.
_____ No restrictions, you may speak with whom ever necessary on my behalf.
_____You may leave messages on my answering machine or voice mail.
_____ I would like appointment reminder calls
_____ I would like to receive text message reminders **Cell phone** (  ) _____
_____ I would like to receive e-mail reminders **E-Mail**_____
_____ You may speak with _____ my spouse, _____ my parents or other person(s) listed below

_____  _____

AUTHORIZATION AND RELEASE

I hereby authorize the release of any information necessary including diagnosis, records, treatment and/or care rendered during the period of my care given by Walter S. Tipton, D.D.S. to third party payors and/or practitioners. I authorize and request my insurance company to pay benefits to Walter S. Tipton, D.D.S. I understand that my insurance company may pay less that the actual amount estimated and that I am responsible for payment of all services rendered on my behalf and my dependents.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We reserve the right to change our privacy practices as described. If we change our practices we will issue a revised Notice of Privacy Practices. You have the right to revoke this Consent at any time. Please understand that if you revoke this consent we may decline to treat you or to continue treating you.

_____  _____
Patient Signature  Date