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. Please allow us at Dr Tipton's Office to protect your rights to privacy by filling out and consenting to your personal restrictions in communications.

I, _____(Patient Name) give permission to disclose my health information and account information to all listed parties below (spouse, children, and /or other family members).

_____ _____

_____ _____

_____ _____

May we leave a message with detailed information? Home: Y N Work: Y N Cell: Y N

May we leave a message with call back number only? Home: Y N Work: Y N Cell: Y N

Other?_____

Written Communications/Mailings? (Excludes Certified Letters)
Home: Y N Work: Y N

AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION INCLUDING DIAGNOSIS, RECORDS, TREATMENT AND/OR CARE RENDERED TO ME OR MY CHILD DURING THE PERIOD OF CARE GIVEN BY WALTER S. TIPTON, DDS TO THIRD PARTY PAYORS AND/OR PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO WALTER S TIPTON, DDS. I UNDERSTAND THAT MY INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYEMNT OF ALL SERVICES RENDERED ON MY BEHALF AND DEPENDENTS.

_____ _____

Patient Signature Date