**KE Dental PLLC**

**Patient Consent Form**

**H.I.P.A.A. Consent Form**

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. H.I.P.A.A., the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is secure.

Kron and Erlandson Family Dental request that each patient sign this consent form which allows us to share protected health information with other offices and insurance companies. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Name of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_

**Authorization to Release Information to Family Members and Others**

Many of our patients allow family members such as their spouse, parents or others to call and request

treatment plans and/or procedures. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your results released to family members or others, you must sign this form. Signing this form will only give consent to release results to the family members or others indicated below.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Kron and Erlandson Family Dental to release my information and results to the following individuals.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Representative Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Leave Messages with Voicemail/Text Message**

From time to time, it is necessary for our office to leave messages for patients to confirm appointments, discuss treatment plans or inquire about insurance or billing information. The purpose of this consent is to leave messages with members of your household or others and/or on your answering service. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_