HIPAA Patient Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

By signing this form, you consent to our use and disclosure of protected health information according to the Notice of Privacy Practices available to you at our front desk. You have the right to revoke this consent at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Bushnell Family Dentistry P.C. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing.

The patient understands that:

- We will NOT release information to any doctor, attorney, life insurance company, workman's comp company without your written consent.
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operation within our office.
- Bushnell Family Dentistry P.C. has a Notice of Privacy Practices that is available for review.
- Bushnell Family Dentistry P.C. reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of the information, but Bushnell Family Dentistry P.C. does not have to agree to these restrictions if, for example, it interferes with payment, daily operation, or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Bushnell Family Dentistry P.C. may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service).

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Patient or Patient Representative Signature Date