BATTLE GROUND
DENTAL
FAMILY PRACTICE

# HIPPA COMPLIANCE

## Consent to the use and disclosure of Health Information

### For treatment, payment or healthcare operations

**Patient Name** _____ **DOB** _____

***I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among many healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and surgical information to my bill.
4. A means by which a third party can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right

1. To object to the use of my health information for directory purposes.
2. To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare to operations and that the organization is not required to agree to the restrictions requested.
3. To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**I request the following restriction to the use or disclosure of my health information:

_____

Patient:

X _____ _____

Signature of Patient or Legal Representative Date Witness Signature

Release info to (spouse, child, guarantor): _____

_____ **I give consent to Battle Ground Dental to leave messages on my home, work, or cell phone answering machine in regards to dental necessity for myself and/or family members.

_____ **I give consent to Battle Ground Dental to text me notifications in regards to my dental appointment.