

**Parkwood Dental Care  
HIPPA Patient Consent Form**

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

Parkwood Dental Care requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. 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.

Authorize

Not Authorized

**Authorization to Release Information to Family Members**

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.P.A we are not allowed to give this information to anyone with the patient's consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow Parkwood Dental Care to release any other information to these family members.

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 Parkwood Dental Care to release my laboratory/radiology results and reports to the following individuals:

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

Authorize

Not Authorized

**Authorization to Leave Messages with Household Members/Answering Machine**

From time to time it is necessary for representatives of Parkwood Dental Care to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of Parkwood Dental Care discuss your medical circumstances or conditions without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

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

Authorize

Not Authorized

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

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