

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA Act of 1996 law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but does not have to agree to those restrictions.
- The practice may condition receipt of treatment upon execution of this consent.

1. May we discuss your medical/dental treatment with others? ☐ Yes ☐ No

If so, please list their names: _____

2. I can be contacted/reminded via email. ☐ Yes ☐ No

3. I can be contacted/reminded via text message. ☐ Yes ☐ No

4. Only contact/remind me via home phone or cell phone. ☐ Yes ☐ No

Office Use of Patient Information

☐ I DO ☐ I DO NOT

allow Drs. Strupp/Brumm to photograph/video record and use for educational or promotional purposes any aspect of my dental conditions or treatment procedures, and to publish such photographs/videos and any testimonials I provide. I further permit Drs. Strupp/Brumm to discuss my conditions/treatment with my physicians, referral doctors and other dental professionals either verbally or in writing by any means including but not limited to electronic transmission such as fax or non-encrypted email. They may also request any relevant medical information from my physicians they deem necessary for my dental treatment.

Sign: _____ Print: _____
Date: _____

