HIPAA Patient Consent Form

ADVANCED PROSTHETIC RESTORATIONS

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. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information (PHI) about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. Advanced Prosthetic Restorations, LLC. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used in treatment, payment or health care operations.
- Advanced Prosthetic Restorations, LLC. has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- Advanced Prosthetic Restorations, LLC.. reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Advanced Prosthetic Restorations, LLC. does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Advanced Prosthetic Restorations, LLC. may condition receipt of services upon execution of this consent.

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL AND FINANCIAL INFORMATION WITH ANOTHER PERSON OR ENTITY?

____NO

____YES, MEDICAL INFORMATION ONLY

____YES, FINANCIAL INFORMATION ONLY

____YES, MEDICAL AND FINANCIAL INFORMATION

If yes, please provide their name, relationship, and phone number.

Name:_____Relationship:_____

Phone number:_____

Name:_____Relationship:_____

Phone number:_____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE/VOICEMAIL?

____YES ____NO If yes, phone number(s):_____

DO YOU PREFER TEXT MESSAGE FOR APPOINTMENT REMINDERS?

____YES ____NO If yes, phone number(s):_____

THIS CONSENT WAS SIGNED BY:

_____

Printed Name of Patient / Date

_____

Signature of Patient or Legal Representative / Date

_____

Printed name Legal Representative if other than Patient / Date