

Heritage Lake Dental

Catherine M. Wong, D.D.S.

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HIPAA Patient Consent Form

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

Wong & Smolnicky P.C. 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.

Authorization to Release Information to Family Members

Authorize

Not Authorized

I authorize Wong & Smolnicky P.C. to release my treatment plan/ account reports to the following individuals:

1. _____ Relation to Patient _____ Date _____

2. _____ Relation to Patient _____ Date _____

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

Authorization to Leave Message with Household Members/Answering Machine

Authorize

Not Authorized

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

Signature of Patient or Representative _____ Date _____

Name of Patient or Representative _____ Date _____