HIPAA Privacy

Name:_____ Date of Birth:_____

Middletown Valley Dentistry and Associates provide information about how we use and disclose protected information about you. Please acknowledge receipt of this office's Notice of Privacy by initialing below:

Initial_____

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive notification of the revision at your next office visit.

Initial_____

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosure in trust on your prior consent.

Initial_____

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 disclosure in trust on your prior consent.

Initial_____

This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____

(Please print name) (Relationship)

_____ _____

(Please print name) (Relationship)

_____ _____

(Signature) (Date)

_____ _____

(Printed name) (Relationship to Patient)