HIPAA CONSENT FORM
From the office of: Children's Dental Health of Lynchburg

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. 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 about you is used or disclosed for treatment, payment and healthcare 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 protected health information about you for treatment, payment and healthcare 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient and parent/legal guardian understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will than cease
- The Practice may condition treatment upon execution of this Consent

Children's Dental Health of Lynchburg (CDHL) is dedicated to protecting the privacy of our patients. Except where required by law, CDHL will NOT authorize treatment, disclose, or discuss any information regarding you/your child's health or financial information with anyone other than the parent or legal guardian, unless otherwise listed below. **Please consider adding certain people such as spouse, grandparents, relatives over the age of 18, babysitters, or other care providers that may need to seek treatment or advice in your absence.**

Name	Relationship to Patient	Phone Number	Permission for the following *circle all that apply*
			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice
			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice
			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice
			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice
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			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice
			*Full access. *Bring in for appointment *Discuss financial/insurance info *Seek medical advice

***NOTE: If permissions are not circled, names listed above will be understood to have full access.**

_____ Patient, parent/legal guardian gives office permission to forward any verified contact information and PHI to patient's specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in the patient's case through verified unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers, will sign a Business Associate Agreement. Patient, parent/legal guardian understands if permission is not granted, USPS, is the only means of communication with those involved in patients' case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient(s) Name: ____________________ Date: ____________

Print Parent/Legal Guardian's Name: ____________________ Date: ____________

Signature of Patient or Parent/Legal Guardian: ____________________ Date: ____________

_____ Patient or Parent/Legal Guardian refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient/legal guardian pick up will be used for PHI transfer.

Office Staff Signature: ____________ Printed Name: ____________ Date: ____________