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HIPAA Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. • Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize you and your staff to leave voice mail messages pertaining to my treatment.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to refer you out to a specialist to complete dental work.
- Seeking a second opinion (Periodontist, Endodontist, Oral surgeon etc...)
- For payment purposes, we may use an outside Collection Agency
- Insurance filling

We are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures other than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your Protected Health Information, please feel free to contact our office at (303)988-7800, between the hours of 9:00-5:00 Monday thru Thursday.

I have read and understand the above Notice of Privacy Practices.

Signed: _____ *Date:* _____