HIPAA CONSENT FORM

Larry L. Folden, D.D.S. Bradley K. Westbrook, D.D.S. Dylan W. Rutherford, D.D.S.

My signature confirms that I have been informed and understand my rights to privacy regarding protected information, 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 provide, conduct and direct my treatment among the appropriate health care providers who may be involved in that treatment directly and indirectly as well as obtain payment from third party payers.

I have read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I also understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment or other health care operations. I understand that All Smiles has the right to change the Notice of Privacy Practices and I have the right to contact this office to obtain a copy.

I have read and understand that in signing this HIPAA form, I acknowledge and authorize, that All Smiles provided this HIPAA Notice of Privacy Practices for my knowledge and my consent.

Patient's name:_____Date of Birth: _____

Relationship to patient (if parent or guardian):_____

Patient or Guardian's signature: _____Date:_____

Authorization for Release of Information to Family Members

I authorize All Smiles Jacksonville to release my medical and/or billing information to the following individual(s):

1._____**Relation to Patient:**_____
2._____**Relation to Patient:**_____
3._____**Relation to Patient:**_____

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.
You have the right to revoke this consent in writing.

Signature:_____ **Date:**_____