HIPPA and RELEASE FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 physicians certifications.

I have been informed by you of your Notice of Privacy Practice contains a more complete description of the uses and disclosers of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this concern. 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 listed to obtain a current copy of the Notice of Privacy Practice.

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 healthcare operations. I also understand that 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 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.

Please name individuals that RCD Dental may discuss treatment and financial arrangements with:

_____

_____

_____

Release Authorization:
I hereby authorize the release of my dental records with respect to any dental care and treatment that may be requested to be transferred. I release RCD Dental from all legal responsibility or legal ability that may arise from release of such information. A reproduced copy of this authorization shall be as valid as the original.

Patient Name:_____DATE:_____

SIGNATURE:_____

RELATIONSHIP to Patient_____

Rose City Dental 126 E Main Street Rose City, MI 48654