Adair Dentistry
2150 E Hwy 290 ~ P.O. BOX 1262
Dripping Springs, TX 78620

HIPAA PRIVACY FORM

Patient Name (print): _____ Date of Birth: _____

By signing this consent form, you consent to our use and disclosure of Protected Health Information. Protected Health Information may be used or disclosed in order to treat a patient, obtain payment for services, or to carry out healthcare operations.
Examples:

*Treatment: sending a specimen, impression, prosthesis, ect.. To an outside laboratory or giving necessary information for filling prescriptions.
*Payment: filing with your insurance company or third party collection agencies.
*Healthcare Operations: pulling a chart or confirming an appointment.

Signing this consent does not allow the practice to obtain or disclose records to other physicians without a signed authorization for each request. Please refer to Notices of Privacy Practices for a more complete description of such uses and disclosures. This Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice, locating in the waiting room at the front desk, before signing the consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. Adair Dentistry provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Privacy Rule, effective April 14, 2003.

Patient understands the following:

*The practice has a Notice of Privacy Practices and the patient has the right to review the Notice prior to signing the consent.
*The practice reserves the right to change the Notice of Privacy Practices.
*The patient has the right to restrict the uses of their information, but the practice is not required to agree to those restrictions.
*The patient may revoke this consent at anytime by writing a letter of request to Laura B. Adair, DDS. However, such a revocation shall not effect any disclosure we have already made.
*The practice may condition receipt of treatment upon the execution of this consent.

_____ _____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

Print name is signed on patient's behalf **Relationship (parent, legal guardian, personal representative)**

For Practice Use Only:

_____
_____
_____

_____ _____

Signature of Practice Employee Date

This information is confidential and intended only for the use of Adair Dentistry.
Unauthorized use is strictly prohibited.