



MAGINNIS
ORTHODONTICS

HIPPA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of our practice (e.g. pharmacies and hospitals)

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. I understand that if I exercise this right, then there can be no communication about the patient with anyone, under any circumstances. Even in extreme circumstances, all information would remain confidential, regardless of the need.

I understand that I make revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the request date will be allowable and agreeable.

Print Patient Name

Responsible Person's Signature

Date

Relationship to Patient