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 may 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

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