PATIENT HIPAA CONSENT FORM

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your/your child's protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocations submitted to the Contact Person listed below. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

To obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, please check with the receptionist or contact:
Sharon Heiliger, Office Manager at 574-264-9499 - Fax:574-264-7883
Address: 4420 E. Bristol St, Elkhart, IN 46514

Signature: I, _____, have had full opportunity to read and consider the contents of
Parent/Guardian or Patient over Age 18
this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to you use and disclosure of my own or my child's protected health information to carry out treatment.

Patient Name: _____Patient Birthdate:_____

Cell Phone # : _____ It is OK to text appointment reminders to my phone: YES or NO

Signature:_____Date_____

INFORMATION SHARING: Our office will not be able to speak to anyone concerning your child that is not listed on this page. You must list anyone that you give permission to:

make appointments discuss financial information including account balances discuss dental health/treatment options bring child to an appointment except for the new patient appointment when we reqire a parent to be here

I give Dr. Robbins permission to discuss my own or my child's dental health with: CIRCLE ALL THAT APPLY

MOM DAD GRANDPA GRANDMA GUARDIAN

The names listed below will be allowed to discuss all dental health, financial information and schedule appointments for my child. I understand the office policy on failed and broken appointmnets and understand that I will be held responsible for any fees charged to my account if I miss an appointment, even if someone else scheduled the appointment.

_____ _____

Please list anyone that you do NOT want to have access to information on your child:

_____ _____

Authorization for use of Patient Photographs and/or video images on social media:

Dr. Robbins' office uses/will use in the future social media to connect with our patients and other offices. "Like" us on Facebook and watch for information about our office and fun contests. Coming soon to other social media such as Instagram and Twitter, etc. Our office will NEVER share full names of our patients or protected health/ personal information.

YES or NO - I grant permission for Dr. Robbins' office to use images of myself/my child on social media. I understand that once an image is online the office will not have any control on how it is used by others.

Signed: _____ Date: _____