Stummer Dental HIPAA Patient Consent

Patient Name_____ Date _____

Please Print

Dr. Stummer and Staff (the practice) abide by the HIPAA guidelines as set by the Federal Government. By signing this, you, as the patient are agreeing to the following:

Reminders of upcoming scheduled appointments may be left on a household answering device, with a family member, or via a text message or voicemail on a personal cell phone. Post cards may also be used.

Protected healthcare information may be disclosed or used for treatment, payment, or healthcare options.

The practice has a Notice of Privacy Practices, and the patient can review this notice. The practice reserves the right to change its Notice of Privacy Practices.

You, as the patient, have the right to revoke this consent in writing at any time.

Health information disclosed by the practice after this consent, may be re-disclosed by the recipient.

Notification of our receipt at the practice of your appliance or other treatment dental work that was sent out to a lab, may be left on a household answering device, with a family member, or via a text message or voicemail on a personal cell phone. Likewise, if the item is late in returning from a lab and it affects your appointment, a message may be left as well.

This consent is agreed to and signed by:

_____ _____

Signature of Patient or Legal Guardian Date

I authorize for disclosure of any of my dental/medical records to the following people:

_____ _____ _____

_____ _____ _____

Name Relationship Phone number