HIPAA with parent/guardian name

First Name

Last Name

Relationship to the patient

Name if not the patient

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: -Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. -Obtain payment from designated third-party payers. -Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link [Link to HIPAA Privacy Practices] or in office in print form). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Peter T. Smrecek Jr DDS Inc has the right to change its Notice of Privacy Practices from time to time and that I may contact Peter T. Smrecek Jr DDS Inc at any time to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that Peter T. Smrecek Jr DDS Inc restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Peter T. Smrecek Jr DDS Inc is not required to agree to my requested restrictions, but if Peter T. Smrecek Jr DDS Inc does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Peter T. Smrecek Jr DDS Inc has taken action relying on this consent.

By checking the box I acknowledge that

☐ I received and read this organization Notice of Privacy Practices