Dr. Gary B. Dempsey and Associates

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protections to your medical records Our benefits office (or third party designated by our office) may sometimes need to disclose dental information or payment information protected by HIPAA in relation to our group dental health plans to your family members or close friends involved in your health care. For example, your spouse may need to contact us to determine whether a particular procedure is covered under our group dental plans or may need assistance filing a claim for dental services. Under HIPAA, unless you specifically object, we are allowed to use our professional judgement in deciding whether to discuss your dental needs and payment information with your family members or close friends. However, we would like to provide you with the opportunity to tell us with whom we may discuss your dental payment or treatment needs with.

( ) You may discuss my dental information with the following person(s):

( ) Please do not discuss my dental information with the following person(s):

( ) Please do not discuss my dental information with anyone excluding my insurance provider that I have provided to your office in the event I do have dental insurance

By signing this I agree to the above and acknowledge that I am aware of the HIPAA privacy requirements

Patient Name _____ Patient Signature_____

Date _____