Health Insurance Portability & Accountability Act (HIPAA) Form

Patient Name______________________________________ Date of Birth____/____/____

I acknowledge that I have reviewed and received a copy (if requested) of this office's Notice of Privacy Practices explaining how this office will use and disclose my protected health information and my privacy rights with regard to my protected health information as well as the office's obligations concerning the use and disclosure of that information. I understand that Okemos Dental Care is commited to maintaining and protecting the confidentiality of my personal information; however due to architectural structure I understand others might hear and see personal information.

Patient can contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures.

Release of Medical Information

I authorize the release of information including the diagnosis records, and examination rendered to me and claims information. This information may be released to (please list names):

( ) Spouse/Significant other: ____
( ) Parent: ____
( ) Children: ____
( ) Other (grandparents, guardian, etc.): ____
( ) This information may not be released to anyone

If spouse, parent, child, or other (grandparents, guardian, etc.) call to pay a bill, they need to be listed on this form, otherwise we will not be able to accept payment.

This release of information will remain in effect until terminated by me in writing.

Patient signature ___________________________________ Date:____/____/____
Parent or Guardian __________________________________ Date:____/____/____
Witness ____ Date:____/____/____

if you wish to have a copy of our HIPAA Notice of Privacy Practices please request one
if you have any questions or concerns, you can contact the office manager or Dr. Brian Zirkle