HIPAA COMPLIANCE CONSENT

DARRYL A. SIMMS, D.M.D.
Dental Excellence of Greater Hartford

860-871-2618
281 Hartford Turnpike, Suite 105
Vernon, CT 06066
www.drdarrylsimms.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of this information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The practice reserves the right to change the policy as allowed by law
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
  No insurance can be billed on the patient's behalf without this signed HIPPA consent form, therefore payment in full will be required at time of services rendered.

May we phone, email, or send a text to you to confirm appointments?	**YES** ☐	**NO** ☐
May we leave a message on your home answering machine or cell phone?	**YES** ☐	**NO** ☐
May we discuss your medical/dental condition with any member of your family?	**YES** ☐	**NO** ☐

If YES, please list individuals with whom we are allowed to discuss:

SPOUSE

CHILD (Children)

OTHER

Patient Name (please print clearly)

Signature **Date:**

Witness **Date:**