

# North Point Dental Associates

## HIPAA CONSENT FORM

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

North Point Dental Associates is authorized to release protected health information about the above-named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For <b>email and/or text communication</b> I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

**Patient Rights:**

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

\_\_\_\_\_  
 Signature of Patient or Personal Representative

Date \_\_\_\_\_

\*Description of Personal Representative's Authority (attach necessary documentation)