CITY VIEW DENTAL

1415 HARNEY STREET, SUITE 100

OMAHA, NE 68102

PHONE (402)341-7576 FAX (402)341-8975

Patient HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree with my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Staying within the reasonable guidelines of HIPAA, I give permission to City View Dental to discuss my dental care and related issues with the following persons, in addition to myself. If none, please state so:

Name: Relationship:

_____

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