Complete Dental
Where we Complete your Smiles

HIPPA CONSENT FORM

As a patient of Complete Dental, I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountably Act of 1996 (HIPAA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involving my treatment.)
- Obtaining payment from third party payers like Insurance companies.
- The day to day operations for your practice.

I have also been given the right to review and obtain a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA.

Signed this _____Day of _____ 20_____

Printed Patient Name_____

Signature:_____

Relationship to Patient:_____