

HIPAA

Patient First Name:

Patient Last Name:

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I acknowledge that I've been offered/received a copy of the Notice of Privacy Practices for Luke M. Sailer, D.D.S.

Signature:

Date:

If this Consent is signed by a personal representative on behalf of the Patient, complete the following:

Personal Representatives Name:

Relationship to Patient:

ADDITIONAL PERSON(S) AUTHORIZED TO THE USE OR DISCLOSURE OF MY PHI

We at Sailer Family Dentistry value and do everything in our power to protect your privacy. Your Dental information will not be given to any individual, if over 18 years of age (Including spouses, parents, children, or any significant other without your written consent). If you want anyone to have access to your Dental information please list their name, relation and phone number below.

1. Name:

Relation:

Phone:

2. Name:

Relation:

Phone:

3. Name:

Relation:

Phone: