Pratt DMD, PC
ROBERT ALAN

HIPAA Compliance Patient Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains patients' rights section describing your rights under the law. You ascertain that 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 consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare options. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in publication. You have the right to revoke this consent in writing signed by you. However, such 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 privacy policy as allowed by law.

*The practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.

*The practice may condition may condition receipt of treatment upon execution of this consent.

This consent was signed by:_____
(Printed Name)

Signature:_____ Date:_____

Witness:_____Date:_____

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