HIPPA

PATIENT CONSENT FORM

I understand that I have the right to privacy regarding my protected health information. These rights are given to me under the HIPAA, Health Insurance Portability Accountability Act of 1996. I understand that by signing this consent I authorize you to use disclose my protected health information to carry out: Treatment, Payment, day to day Healthcare Operations of our Practice.

I have been informed of, and give the right to review and secure 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 the HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry treatment, payment, and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with the restrictions.

I understand that I may revoke this consent, in writing at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I,_____ give consent for Dr.Geist, from Southbay Periodontics & Implantology to allow to release any medical and personal information requested by insurance, doctors, or laboratories. This information will be kept confidential as per the HIPPA of 1996

_____ _____

Patient Signature Employee Signature

_____Date