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Consent for Disclosure of HIPPA Protected Health & Medical Information

Patient information will be kept confidential except as in necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary.

My protected health information can be released to the following people:

Name: _____ Relationship to Patient: _____

Phone (home/cell): _____ Employer/Phone#: _____

Name: _____ Relationship to Patient: _____

Phone (home/cell): _____ Employer/Phone#: _____

With this consent, I give Sandusky Dental Partners permission to call my home or in person to someone listed above in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care and physical health.

_____

Patient signature (patient, guardian, or legal representative) Date

PLEASE COMPLETE BOTH SIDES OF FORM