HIPAA CONSENT FORM

Patient Name:______________________________________

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I herby give my consent for Dr. David W. Goris, DDS and Beautiful Smiles (collectively referred to as Beautiful Smiles hereafter) to use and disclose protected health information and understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal healthcare operations such as assessments or evaluations, and physician certifications.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Dr. Beautiful Smiles has the right to change its Notice of Privacy Practices from time to time and that I may contact Beautiful Smiles at any time to obtain a current copy of the Notices of Privacy Practices.

With this consent, Beautiful Smiles may call my home or other alternative location and leave a message in person or via voicemail or text in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and calls pertaining to my clinical care, including laboratory results among others. I further provide consent for Beautiful Smiles to mail or email my home or other alternative address(es) any items that assist the practice in carry out treatment, payment and healthcare operations, such as appointment reminders and patient statements.

I understand that I may request in writing that Beautiful Smiles restricts how my private information is used or disclosed to carry out treatment, payment and healthcare operations. I also understand that Beautiful Smiles is not required to agree to my requested restrictions, but if Beautiful Smiles does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Beautiful Smiles has taken action relying on this consent. If I do not sign this consent, or later revoke it, Beautiful Smiles may decline to provide treatment to me.

Receipt of Notice of Privacy Practices: Through this written acknowledgment, I confirm that I have received and have had the full opportunity to read and consider Beautiful Smiles' Notice of Privacy Practices.

By signing this form, I am providing my consent to Beautiful Smiles to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

I authorize Beautiful Smiles to disclose my protected health information to the following individual(s):

Name:______________________________________ Relationship:______________________________

Name:______________________________________ Relationship:______________________________

Name:______________________________________ Relationship:______________________________

Signature of Patient, Parent or Legal Guardian (responsible Party)

Signature:__________________________________ Relationship:______________________________

Printed Name:_______________________________ Date:____________________

8/20/2016