McMinnville Family Dental
325 NE 6TH STREET
McMinnville, OR 97128

# HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

**The patient understands that*:***

- Protected health information may be disclosed or used for treatment, payment or health operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions
- The patient may revoke this Consent in writing and all future disclosures will then cease.

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**Printed** Name of **Patient** **Date**

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**Signature** (Patient or Guardian) **Relationship to patient**

Please list whom we may discuss your treatment with and their relationship to you

1. _____
2 _____

May we leave messages on your home or cell phones? _____