HIPAA Consent Form &
Acknowledgement for the Notices of Privacy Practices

Patient Name (Print): ______________________ **Patient Date of Birth:** _______________

As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of Civil Rights, we are not permitted to release patient information except as stated in the Notice of Privacy Practices or in accordance with your wishes as stated below.

This consent authorizes Bonnie Helfner DDS PC to send/give my medical information as noted below:

- Leave a voicemail including my Personal Health Information on my cell phone _______Yes_______No
- Leave a voicemail including my Personal Health Information on my home phone _______Yes_______No
- Leave a voicemail regarding appointments, cancellations; confirmations on my home/cell ______Yes_______No
- Use of electronic communication for prescriptions, referrals, and x-rays ______Yes_______No
- Permit the individual stated below to receive appointment/treatment related information ______Yes_______No
- Speak to a family member of my choosing regarding my Personal Health Information: ______Yes_______No

Designated Representative (Print): _________________ **Relationship to Patient (Print):** ______________

On this date I have received and reviewed the Notice of Privacy Practices, which describes how my medical information may be used and disclosed and explains how I can get access to this information. I understand that my medical information may be maintained in an electronic health record and accessed remotely or transmitted securely over the Internet.

The authorizations made above will remain effective until such time as I notify Bonnie Helfner DDS, PC in writing, by certified mail, of requested changes.

Patient [or Parent/Guardian/Representative] **Signature:** _________________________ **Date:** ________________

Print Full Name: ___________________________________ **Relationship to Patient (Print):** ______________