Orange County
Pediatric Dentistry
Dr. Dayna Olstein
Dr. Arielle Rolon

# HIPAA Acknowledgment

## PATIENT INFORMATION

| First Name | | Last Name | | DOB | |
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Please click on the hyperlink to obtain a copy: *Notice of Privacy Practices*

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. The terms of Notice may change. 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 your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosure will then cease.
- The practice may condition treatment upon the execution of this consent.

Please list the names of anyone you would like us to release information regarding the patient's treatment to should they call on your behalf.

Printed Name Relationship to Patient

Printed Name Relationship to Patient

Printed Name Relationship to Patient

## FORM COMPLETION

| Signature of Patient, Parent or Guardian: | | Date: | |
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**IF PATIENT IS A MINOR**

| Form signed by: | | Relationship to Patient: | |
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