HIPAA Dental Form

Patient information	
Name	Date of birth
Phone number	Email address
Address	
Emergency contact	
Name	Relationship
Contact details	
Appointment information	
Appointment date	Appointment time
Dental provider	Contact number
Consent for use and disclosure of protected health information (PHI)	
I, _____, hereby authorize _____ and its affiliated healthcare providers to use and disclose my protected health information (PHI) for the purpose of treatment, payment, and healthcare operations as outlined in the Notice of Privacy Practices provided to me.	
Purpose of disclosure	

Additional authorizations	
I understand that I have the right to request restrictions on the use and disclosure of my PHI. However, I acknowledge that the dental office is not required to agree to these restrictions. I also acknowledge that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization.	
Patient’s signature	Date
Privacy officer (dental office representative)’s name and signature	Date
Witness (if applicable)’s name and signature	Date