HIPAA Consent

HIPAA is a federal law developed to give individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communication of PHI that may be made by alternative means or correspondence.
The purpose of the Notice of Privacy Practice is to explain how Peter F. Hazim, D.D.S. may use or disclose your health care information. This Notice also explains the rights that you are guaranteed under HIPAA regulations. All information provided on this form is part of your Protected Health Information and will NEVER be shared with a 3rd party.

Patient Information

First Name *

Last Name *

Date of Birth *

Please provide us the best phone number(s) to contact you

Home Phone (___) ___-____

Cell Phone (___) ___-____

Work Phone (___) ___-____

Ext

May we call the phone number(s) above and leave detailed voice messages regarding your appointments, billing matters and/or medical information?
○ Yes ○ No

Would you like to be notified of and confirm appointments via text messages?
○ Yes ○ No

Would you like to be notified of and confirm appointments via emails?
○ Yes ○ No

Would you like to receive special offers or internal promotions via emails?
○ Yes ○ No

Please list the person(s) you give permission to us to disclose your appointments, billing matters and or medical information with

Name

Relationship

Name

Relationship

Name

Relationship

You may refuse to sign this acknowledgement

By signing below, I hereby acknowledge that I have received a copy of Peter F. Hazim, D.D.S.'s Notice of Privacy Practice. I have read and understand this HIPAA privacy rule. I have also agreed to allow Peter F. Hazim, D.D.S. and the employees thereof to relay detailed messages regarding my appointments, billing matters and or medical information to myself or the above named representatives as specified.

Name and Email of Signing person

First & Last Name *

Email Address *

Date

Signature

Sign above