HIPAA Privacy

I understand that according to the Federal HIPAA law that this office is unable to discuss my treatment, account balance or any other matters pertaining to me unless I indicate that they may do so. I agree that the following people can be informed of any association that I may have with this office including, but not limited to treatment, diagnosis, financial agreements, account balances and my general well-being.

Please List:

1. ____
2. ____
3. ____

This consent applies until I ask that the name be deleted and a new form replaces this one. I certify that I have received a copy of the Join Notice of Privacy provided by Dr. Mindy's Family Dentistry.

Patient Signature: ______________________________ Date: ______________

Practice Representative: ___________________________ Date: ______________

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