Dr. Bruce M. Crawford
Implant Dentistry & Laser Periodontics

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# Notice of Privacy Policies Consent

**Our Notice of Privacy Policies 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 our 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.**

**By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

**The patient understands that:**

- Protected Health Information may be disclosed or used for treatment or payment.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

Name of Patient / Legal Guardian _____ Relationship to Patient _____ Date _____

**Unless you opt-out in writing in our Notice of Privacy Practices that is posted or that we provide to you, the practice discloses a limited amout of your health information to family members, friends, or others you have identified below when you are unavailable, incapacitated or an emergent condition and we think it is in your best interest.**

## PLEASE SELECT ONE OF THE HIPAA NOTIFICATIONS BELOW (check one)

❑ My Health Information may be released to: (*Name / Relationship to Patient*)

(1) Name _____ Relationship to Patient _____ (2) Name _____ Relationship to Patient _____

Name of Patient / Legal Guardian _____ Date _____ Witness Name _____

**OR**

❑ I am electing to opt-out so that no Health Information is released to family, friends, or others.

Name of Patient / Legal Guardian _____ Date _____ Witness Name _____