PETER J. GAIDIS, D.M.D
989 N. MAIN STREET
WILLIAMSTOWN, NJ 08094
(856)629-7806

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

PATIENT GIVING CONSENT:

NAME:______________________________

DATE OF BIRTH:______________________________

SOCIAL SECURITY #:______________________________

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

PATIENT CONTACT INFORMATION: Home #______________________,

Cell #_____________________, Work #_________________________Ext.________

I authorize brief and/or extended messages with dental/medical information to be left on voicemail at (check all that apply): ___Home ___Cell ___Work

I authorize electronic communications be sent to my E-mail address:___________________

Restrictions/Instructions:____

RELEASE OF MEDICAL HISTORY/TREATMENT INFORMATION: I authorize the following individual(s) to receive information pertaining to any dental/medical history and treatment received:

Name:________________________Relationship:____________DOB:________________

Phone#:______________________

Name:________________________Relationship:____________DOB:________________

Phone#:______________________

Restrictions:____

RELEASE OF BILLING INFORMATION: I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name:________________________Relationship:____________DOB:________________

Phone#______________________

Name:________________________Relationship:____________DOB:________________

Phone#______________________

Restrictions:____

PRINT NAME:____

SIGNATURE:____

DATE:____