HIPPA Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.P.A., the Health Insurance Portability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

Morristown Dental Associates L.L.P. **(Dr. Richard Carrara & Dr. Vincent Corsello)** requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. 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, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. **[Please initial one]**

_________ **Authorize** _________ **Not Authorized**

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and discuss treatment. Under the requirements for H.I.P.P.A we are not allowed to give this information to anyone without the patient's consent. If you wish to have your information released to family members you must authorize and sign this form. Signing this form will give consent to release laboratory and radiology results as well as discuss treatment proposals and financial policies/arrangements to the family members listed below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your own prior consent.

I authorize Morristown Dental Associates to release my information to the following individuals:

1.________________________________ Relation to Patient ____________________ Date__________

2.________________________________ Relation to Patient ____________________ Date__________

[Please initial one]

_________ **Authorize** _________ **Not Authorized**

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of **Morristown Dental Associates** to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the staff would like to discuss lab or procedure results or to ask a patient to call the office regarding an issue or concern. At no time will a representative of **Morristown Dental Associates** discuss your medical circumstances or conditions without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent. **[Please initial one]**

_________ **Authorize** _________ **Not Authorized**

Signature of Patient or Representative ____ Date____________

Print Name of above patient/representative ____________________________________ Date____________