PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Part of your treatment may include photographs of the face and teeth/smile. We may desire to use the photographs taken of you by our office for treatment, educational, and/or advertising purposes. However prior to using any photographs for advertising purposes we will obtain consent from the patient, parent, or legal guardian.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice

Print Name:______________________ Signature________________________ Date________

*Compliance Assurance Notification available upon request

INFORMED CONSENT TO PHOTOGRAPH

Date________________

I, ________________________________, due hereby give consent for Dr. LeGrand
(Legal Guardian)
Bingham’s Family Dentistry to take and/or display photograph(s) of the face and

teeth/smile of ________________________________. The photograph will be used for
(Patient’s Name)
educational and/or advertising purposes by Bingham Plaza Dental Care and may be displayed within our office and/or on the dental office’s webpage, www.docbingham.com. Dr. Bingham’s office and staff will protect the patient’s personal data, such as name, age and date of birth, from being displayed.

Print Name:__________________________ Signature_________________________

Relation to Patient:
___Self ___Guardian Witness___________________________