McMurphy Family Dentistry

Amanda McMurphy, DMD

HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights have been given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form, I authorize Dr. Amanda T. McMurphy to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)
- Obtaining payment from third party payers (e.g. insurance company)
- Day-to-day healthcare operations of the practice (email/ text reminders/ confirmations of appointments via online service)

I have also been informed of, and given the right to review, a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Dr. Amanda T. McMurphy reserves the right to change the terms of the notice and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. I understand that you are not required to agree to these restrictions. However, if you do agree, you are bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Patient Printed Name: _____

Signature: _____

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