1702 Oak Street
Kenova, West Virginia 25530
304.453.6765

Select Dental
A GHAREEB DENTAL GROUP AFFILIATE

5089 Elk River Road North
Elkview, West Virginia 25071
304.965.1200

www.selectdentalwv.com

MITRI A. GHAREEB, DDS, FAGD | JOSHUA B. MASSEY, DDS | GEORGE DIRANI, DDS | BROOKE TOLLIVER, DDS | KARLEE ALDERMAN , DDS

Patient Consent - HIPPA Acknowledgment & Authorization Form

CONSENT TERMS

- I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
- I have been informed that I may review the practice/clinic's Notice of Privacy Practices before signing this consent.
- I understand that this practice/clinic has the right to change their privacy practices and I may obtain any revised notices at the practice/clinic.
- I understand that I have the right to request a restriction of how my protected health information is used; however, the clinic is not required to agree.
- I understand that I may revoke this consent at any time in writing, applicable from the date of revocation forwards.
- I authorize my insurance company to pay benefits directly to the dentist or dental group.
- I certify that all health history and registration information is accurate to the best of my knowledge.

HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. This information will be used to:

- Conduct, plan, and direct treatment and follow-up among multiple healthcare providers.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices. I understand I may request in writing that you restrict how my private information is used or disclosed, though the organization is not required to agree to requested restrictions.

45 - C.F.R. #164.508

STATEMENT OF INTENT

HIPAA limits disclosure of individually identifiable health information to certain family members and friends. I am signing this authorization so my healthcare provider can disclose and discuss my information with the persons listed below.

AUTHORIZATION

I, ____, hereby authorize my physicians, nurses, hospitals and other healthcare providers to fully disclose my individually identifiable health information to any or all of the following:

1702 Oak Street
Kenova, West Virginia 25530
304.453.6765

Select Dental
A GHAREEB DENTAL GROUP AFFILIATE

5089 Elk River Road North
Elkview, West Virginia 25071
304.965.1200

www.selectdentalwv.com

MITRI A. GHAREEB, DDS, FAGD | **JOSHUA B. MASSEY**, DDS | **GEORGE DIRANI**, DDS | **BROOKE TOLLIVER**, DDS | **KARLEE ALDERMAN** , DDS

Patient Consent - HIPPA Acknowledgment & Authorization Form (PAGE 2)

AUTHORIZED REPRESENTATIVE 1

- NAME: ______________________________
- ADDRESS: ______________________________
- CELL PHONE: ______________________________ OK to text? ❑ Yes ❑ No
- HOME PHONE: ______________________________ OK to leave voice mail? ❑ Yes ❑ No
- EMAIL: ______________________________

AUTHORIZED REPRESENTATIVE 2

- NAME: ______________________________
- ADDRESS: ______________________________
- CELL PHONE: ______________________________ OK to text? ❑ Yes ❑ No
- HOME PHONE: ______________________________ OK to leave voice mail? ❑ Yes ❑ No
- EMAIL: ______________________________

Patient's Printed Name: ______________________________ DOB: ______________

AUTHORIZED PERSONS FOR DISCLOSURE

Patient Name: ______________________________

Patient Signature: ____________________ Date: ______________ Patient DOB: ______________

Parent/Guardian (if minor): ____________________ Signature: ______________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment, but was unable to do so as documented below:

Date: ______________ Initials: ______________ Reason: ______________________________