FAMILY DENTISTRY

A LIFETIME OF GREAT DENTAL CARE

Samuel E. Schmitz, DDS • Frank David Fickas, DDS • Alisa Fabiano, DDS • Alyssa Biggerstaff, DMD

PATIENT RELEASE OF INFORMATION AUTHORIZATION FORM

Under HIPAA guidelines Family Dentistry needs your authorization to disclose any protected information to other persons on your behalf. This information includes x-rays, billing, and medical information.

Please indicate to whom we may release this information to on your behalf i.e. husband, brother, children etc.

_____

_____

You have the right to

- Revoke this authorization.
- Refuse to sign authorization knowing that we will not be able to release any of your information to any other family members or friends.

I understand that information disclosed pursuant to this authorization may be subject to additional disclosure by the recipient and no longer protected by HIPAA.

Financial Responsibility:

I understand that I am responsible for all charges associated with services and that I will be responsible for any past due balance(s) as well as a **1.5% monthly finance charge on all past due accounts**. Past due patient accounts that do not have agreed-upon financial arrangements with Family Dentistry will be submitted to a collection agency or attorney for collection. I will also be responsible for all attorney fees and court costs incurred in the collection of any past due balances.

Print Patient Name:_____

Relationship (if other than patient):_____

Signature:_____

Date:_____

Family Dentistry
10655 State Road #662 – P.O. Box 185
Newburgh, Indiana 47629
Phone # (812) 853-3313
Fax#(812)858-0087

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DAVID G. OGLE, DDS • SAMUEL E. SCHMITZ, DDS • F.DAVID FICKAS, DDS • ALISA FABIANO, DDS

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you 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. my insurance)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure 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 you reserve the right to change the terms of this notice from time to time 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 health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restriction.

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.

Signed this ___ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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