Form B HIPPA CONSENT

Timothy M Brooks DDS

Patient Consent for Use and Disclosure of Health Information and Verbal Release of Protected Health Information.

I, _____, **DOB**_____ have received and reviewed a copy of Dr Brooks' Dental Office Notice of Privacy Practices and Security Policies and Procedures.

This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.

I hereby authorize Dr Brooks and/or members of his staff to release the following Personal Health information: 1) Dental Services claims information 2) Prescriptions, Diagnostic, treatment and/or management services 3) Review required HHS or HIPPA-compliant health care operations 4) Communications from the dental office by telephone, email, fax or postal services or any means that the office feels efficient to contact me regarding the above mentioned statements.

My Consent Effective Today **Date_____**

Continue Indefinitely: I understand that consent maybe revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient or Guardian Signature_____

Personal Representative _____Date _____

OK to leave messages containing confidential information on voicemail to this and/or these numbers:

Home_____Cell_____

Work _____Email_____

If there are persons or entities that you would like us to be able to speak to about your care please list below:

Name _____Relationship:_____

Name _____Relationship:_____

Name _____Relationship:_____