David M. Briller, DMD PC
Family & Cosmetic Dentistry
P: 856-629-5522 F: 856-629-8361

HIPAA CONSENT FORM

Patient Name: _____

HIPAA – Notice of Privacy Practice

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how Dr. David Briller DMD Family & Cosmetic Dentistry may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though Dr. David Briller DMD Family & Cosmetic Dentistry has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. Signing below indicates that you have received the Notice of Privacy Practice. If you have any questions, please contact our HIPAA Compliance Officer: Aleisha Potter.

I hereby acknowledge that I have received a copy of Dr. David Briller DMD Family & Cosmetic Dentistry Notice of Privacy Practices.

Permission to Share my Medical Information may be obtained and exchanged verbally to:

Name and their Relationship: _____

Signature of Patient/Guardian: _____

Permission to Bill Your Insurance

All professional services rendered are charged to the patient. Necessary forms will be completed by Dr. Briller DMD Family & Cosmetic Dentistry to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage.

I understand my signature authorizes releasing of the information to the insurer or agency given to Dr. David Briller DMD Family & Cosmetic Dentistry for participating health insurance plans.

Signature of Patient or Guardian: _____ Date: _____