NorthRock Dental (dba Scheer Dentistry) Patient Consent Form

HIPAA Consent Form:

(Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

I understand that, by signing this consent form, **I have been given the opportunity to review and ask questions regarding NorthRock Dental's (dba Scheer Dentistry) Privacy Practices and am giving my consent to release my records** to entities which may be involved in my care including but not limited to insurance companies, healthcare professionals, family members, etc. except for the following entities________________________. This authorization for release of information covers the period of healthcare past, present and future.

In addition, in accordance with the **TCPA** (Telephone Consumer Protection Act), I give Scheer Dentistry or any entity represented by them permission to contact me on my cell phone.

Revocation of Consent: I understand I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name Signature Date

Release of Records:

________I understand that, by initialing this consent form, I am consenting to release my dental records from Scheer Dentistry such as x-rays, letters, and records to other offices or entities as needed or as requested.