JOHN C. WARREN, D.M.D.

HIPAA COMPLIANCE

As required by the **Health Insurance Portability and Accountability Act** of 1996 (HIPPA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our privacy policy. You have the right to review our privacy policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I, ___________________________, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the privacy policy of John C. Warren, D.M.D./Warren Family Dental.

Please allow the following person(s) to obtain my healthcare information INCLUDING CHILDREN OR SPOUSES.

_________________________________ _________________________________

_________________________________ _________________________________

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the use and disclosure of my health information. (Please describe in detail)

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Patient Signature ____ Date ________________

CONSENT FOR TREATMENT

The undersigned authorizes Dr.Warren to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Warren to make a thorough diagnosis of the patient's dental needs. I also authorize Dr.Warren to perform any and all forms of treatment, medication and therapy, that may be indicted in connection with (name of patient) ____________________ and further authorize and consent that Dr. Warren choose and employ such assistance as he seems fit. I also understand payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of the note.

Patient _________________________________ Date ___________ Witness______________________________

Parent/Responsible Party____

Relation to Patient ____