Patient Consent to Share Information

Dental Arts of Bedford

By signing below, you consent to the disclosure of your protected health information by Dental Arts of Bedford, the Doctors, our staff, and/or our business associates for the purpose of communicating your health information with the individual(s) you list below. By signing below you are waiving your rights to privacy, outlined in the HIPPA law, so that this communication can take place.

Should you choose to reconsider this waiver, you have the right to request *in writing* that we once again restrict our disclosures of your protected health information in the future. Doing so would render this waiver void.

I HAVE PERSONALLY REQUESTED, UNDERSTAND, AND AGREE TO THE CONTENT OF THIS WAIVER, REGARDING THE PROTECTION OF MY PRIVATE HEALTH INFORMATION, AND I GIVE PERMISSION FOR IT TO BE DISCUSSED WITH THE PERSON(S) NAMED BELOW.*

PATIENT GIVING CONSENT:______________________________ Date:______________
(please print clearly)

PATIENT SIGNATURE:____

INDIVIDUAL(S) WHO MAY RECEIVE/DISCUSS MY PROTECTED HEALTH INFORMATION:

NAME:____

NAME:____

NAME:____

NAME:____

**This waiver is only valid for patients who are 18 years of age or older. If the patient is a minor (under 18 years of age)this dental office can and will disclose protected health information to the minor's parent(s) and/or guardian(s) as is appropriate to the care and treatment of the said minor-patient.*