Ocean View Dental

Office of:
Summer T. Wood, D.M.D.
Keith Vodzak, D.M.D., M.S.D. (Orthodontist)
Keith Dung, D.D.S., Andrea Braun, D.D.S.
970 North Kalaheo Avenue, Suite C309, Kailua, HI 96734
Phone (808) 254-5503 Fax (808) 254-4645

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review the Notice
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this Consent

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The Consent was signed by: _____
Signature and date of patient or representative

Printed name of Patient or Representative

Relationship of patient (if other than patient) _____

Witness: _____
Signature and date of Practice Representative

_____
Printed Name- Practice Representative