PERIODONTAL ASSOCIATES
NEW JERSEY

# Patient Consent Form

In April 2014, new updated federal requirements regarding privacy of information for health care patients took effect. H.I.P.A.A., the Health Insurance Portability and Protection Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe. Periodontal Associates of NJ requests that each patient sign this consent form, which allows us to share protected health information with entities and people involved in your health care and insurance company. 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, except where we have already made disclosures in reliance on your prior consent.

Name of Patient/Guardian:_____

Signature of Patient/Guardian:_____ Date: _____

Authorization to Release Information to Authorized Individuals:

Many of our patients allow individuals such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results, photography, video, radiographs, scans, treatment, procedures and any other medically pertinent information released to individuals, you must sign below. Signing below will only give consent to Periodontal Associates of NJ to release information (as stated above) to the individuals indicated below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. I authorize Periodontal Associates of NJ to release test results, photography, video, radiographs, scans, treatment, procedures and any other medically pertinent information to the following individuals.

1. _____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Signature of Patient/Guardian: _____ Date:_____

Authorization to Leave Messages with Household Members/Answering Machine:

From time to time it is necessary for representatives of Periodontal Associates of NJ to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab, pathology or procedure results, or to ask a patient to call Periodontal Associates of NJ regarding an issue or concern. At no time will a representative of Periodontal Associates of NJ discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient/Guardian: _____ Date:_____