HIPAA

Patient Name: John Doe **Birth Date:** 5/14/2011

Dr. Patrick R. Gallagher III, D.D.S., P.A.

Drs. Patrick Gallagher and Caitlin Gallagher-Kuhn

HIPAA Consent Form

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Your health information will be used for treatment, payment, and health care operations.

Treatment - Information obtained by your health practitioner in this office will be recorded in your medical/dental record and used to determine the course of treatment that should work best for you. This consists of your health care provider recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in your care, such as specialty providers or lab technicians.

Payment - Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations - The medical/dental staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide. We may also use your health information to communicate with other health care providers to coordinate your care.

Signature

Date of signing	5/14/2020
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1