Charles J. Perruzzi, DMD
Joshua B. Austein, DMD
Lindsay J. Bachrach, DMD

HIPPA CONSENT FORM

Patient Name: _____
Patient Phone #:_____

HIPAA – NOTICE OF PRIVACY PRACTICE

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how West Ridgewood Dental Professionals may use or disclose your protected health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Though West Ridgewood Dental Professional has always taken great care to protect the integrity and confidentially of our health care information, we are not required by the HIPAA Privacy Rule to distribute this notice to you and obtained acknowledgement that you have received the Notice. Signing below indications that you have received the Notice of Privacy Practice. If you have any question, please contact our HIPPA Officer Carol Gil.

I hereby acknowledge that I have received a copy of West Ridgewood Dental Professionals Notice of Privacy Practices.

_____
Signature of Patient/Guardian

PERMISSION TO SHARE MEDICAL/DENTAL INFORMATION
All my medical and dental information may be obtained and exchanged verbally, in person and phone to:

_____
Name / Relationship / Phone Number

_____
Name / Relationship / Phone Number

_____ _____
Signature of Patient/Guardian Date

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