Cris Turman DDS

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from the third-party payers (ex. insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. This notice takes effect 02/16/2026 and will remain in effect until we replace it. I understand that you reserve the right to change the terms or this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

The Hipaa Privacy Rule gives Linton Dental permission to communicate & disclose limited information with family members or other persons associated with their care.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

You may request a copy of our notice at any time. Cris Turman, DDS, PO Box 430, Linton, ND 58552. Tel # 701.254.4521. www.info@turmandental.com.

Patient's name _____Date_____

Patient/Guarantor signature_____ Date_____