Health Insurance Portability & Accountability Act (HIPAA)

I have been provided the opportunity to review the Notice of Privacy Practices.
I, the undersigned, authorize River's Edge Family Dental/ Calen Leider to send/receive confidential healthcare information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 996, 45 C.F.R., Parts 160-164) by facsimile to healthcare providers, hospitals, laboratories, and other medical caregivers for the coordination of care for the patient listed below.
I agree that the dental practice may communicate my PHI's via email, and I am aware of the risks associated.
I may revoke this authorization by five (5) days written notice to River's Edge Family Dental.

Assignment of Benefits Financial Agreement

I hereby authorize payment of insurance benefits to be made directly to River's Edge Family Dental/ Calen Leider and any assisting physicians for services rendered.
I understand that I am financially responsible for all charges whether or not covered by my insurance carrier.
I also authorize River's Edge Family Dental/ Calen Leider to release all information necessary to secure the payment of benefits. A photocopy of this agreement shall be valid as the original.

Please list any individuals you wish to allow access to your medical & financial records.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient Name:_____

_____

Patient (or Guardian) Signature Date