BABAK NOOHI, D.D.S., M.S.

CAPITOL HILL DENTISTRY

HIPAA COMMUNICATION CONSENT FORM

This Notice Describes How Health Information about You May Be Used And Disclosed and How You Can Get Access to This Information.

Please Review It Carefully and Sign It at the Bottom

I authorize Dr. Babak Noohi and staff leave messages on my voicemail/text messages to confirm appointments, and/or may speak with other members of my household to leave messages with them regarding my appointments via mail, email, home phone, office phone, cell phone numbers.

Please initial for acknowledgement: ☐

I hereby authorize that Dr. Babak Noohi and staff may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

I hereby authorize that Dr. Babak Noohi and staff may disclose my personal health information to the person who I have listed as my emergency contact. .

I understand that Dr. Noohi's may use my radiographs and clinical images of my teeth for teaching purposes (i.e. lectures, case presentations). No patient identifiers will be visible at any time.

I understand that at any time I have the right to revoke this consent or request to know how my protected health information is being used or disclosed to carry out treatment, payment, and healthcare operations.

I understand that any such request of my patient record must be provided by me to the practice in writing.

By my signature below, I affirm the above information.

Patients' Signature: ☐ Date: ☐

Print your name: ☐

Signature of Guardian/Authorized Representative: ☐

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