Jonathan F. Goldman, DMD

HIPAA PATIENT COMMUNICATION FORM

It is the policy of this office not to release confidential medical information regarding your treatment to family members or friends exept for *parent/legal guardian*, other persons authorized by the patients, as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam *room/recovery room*, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency situation, or as otherwise permitted by the health insurance portability and accountability act of 1996. (HIPAA).

If you need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. By signing below, you authorize the following people to receive information regarding your treatment or care: (If you wish to add names later on, please confirm this in writing).

Spouse: ____ Yes No

Parent: ____ Yes No

Other: ____ Yes No

Alternative Communications: You are also entitled to specify alternative reasonable means of communication if you do not wish to be contacted by us in a certain way.

Home (answering machine) Yes No Work (answering machine) Yes No

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Name of patient: ____

I hereby acknowledge that a copy of this medical practice's **Notice of Privacy Practices** is available in the reception area and that I may request a copy of this notice at each appointment.

INFORMED CONSENT - I AUTHORIZE:

-Jonathan F. Goldman, DMD to forward any medical information to the referring physician(s) regarding (my/my childs) treatment, and to submit information to my employer and/or their insurance carrier, (for workers compensation only). I understand the information released may include psychiatric, drug, alcohol, and/or HIV/AIDS information/ the confidentiality of this record Is protected by the Federal Confidentiality Regulations Act of the Connecticut General Statutes. -This information shall not be forwarded to anyone else without my written consent or other authorization as provided in the statutes.
-Jonathan F. Goldman, DMD to release to the insurance carrier any information needed for the payment of any claim, I permit a copy of this authorization to be used in place of the original and request payment of medical/dental insurance benefits either to myself or to the party who accepts assignment.
-Payments to Jonathan F. Goldman, DMD form my insurance carrier and agree to pay any applicable copayments at the time of service. I understand that my health insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance.
-Testing and treatment procedures as deemed necessary by Jonathan F. Goldman, DMD.

I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR THE LEGAL GUARDIAN FOR A MINOR). AND I ACCEPT THE TERMS AS ABOVE.

____ ________________________________

Signature of Patient (Responsible party if patient is a minor) **Date**
(Signature is valid for 18 months)

If you have been assigned guardianship of the minor patient, you must present proof of guardianship, such as a court document or DCF paperwork.