GAITHER PERIO
HIPAA AND PHOTOGRAPHY CONSENT

In General, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

We are dedicated to helping you maintain and enjoy a healthy smile for a lifetime! We will explain and discuss treatment cost prior to procedures. Treatment recommendations at this office are made to improve your oral health and accomplish your health goals.

During your treatment, photographs and/or video may be taken. I authorize that these photographs and/ or videos can be used for diagnostic and teaching purposes.

By signing below, I acknowledge that I have read and understand the above information and have had any specific questions answered. I agree to accept correspondence from this office through any given contact information, including messages. I authorize the office to send my insurance carrier any necessary information about my condition so that prompt and accurate payment can be made. I also authorize my insurance company to make payment directly to this office. This authorization will remain in effect until I notify the office in writing otherwise.

Privacy Statement- This office shares no information with anyone outside the office regarding your dental or medical condition. Only when appropriate for your care will we discuss your treatment with your other medical professionals or authorized family members.

Signature of patient, parent, or guardian (responsible party)

_____Date: _____

Relationship to Patient_____

Person/s whom we may discuss your treatment and health

_____