HIPAA Consent Form

Patient Name:_____

HIPAA – Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Wigal Orthodontics may use or disclose your protected health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Our Notice of Privacy Practices is available for you to view on our website, www.wigalorthodontics.com, or a copy can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

I certify that I have had the opportunity to review the Notice of Privacy Practices of Wigal Orthodontics.

Name of Responsible Party_____

Relationship to Patient_____

Signature_____

Date_____