

**Dr. John F. Saunders, DDS, PA**

**HIPAA CONSENT FORM  
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

To Our Patients:

Patient information will be maintained by Dr. John F. Saunders' office as described by the Notice of Privacy Practices in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting the front desk personnel.

Dr. Saunders reserves the right to release your healthcare information based upon any medical emergency situations and in general for continuity of care. We will release your information as needed to third party payers in order to receive payment for services. We will use your information as needed to maintain internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

Call you to remind you of your next appointment and/or leave information on your answering machine.

At what number(s) would you like to be contacted? \_\_\_\_\_  
\_\_\_\_\_

If we cannot contact you at the above number(s), numbers from the information sheet will be used.

If there is anyone that you would like us to share your information with, please list the names below:

\_\_\_\_\_  
\_\_\_\_\_

I have read and understand my rights.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of patient