Sharon E. Lister, D.D.S., P.C.

PATIENT HIPAA CONSENT FORM

3710 N. Oracle Rd.
Tucson, AZ 85705
(520)623-9479

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that at any time I may request a complete copy of the office's Notice of Privacy Act and Office Policy. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means by which a third-party payer can verify that services billed were actually provided

I understand that the office has the right to change its Notice of Privacy Practices from time to time, and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

_____

Patients Name (print)

_____

Signature of patient or

_____

Legal Representative / Relationship to Patient

_____

Date