PATIENT CONSENT

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment;
Obtaining payment from third party payers (e.g. my insurance company);
The day-to-day healthcare operation of your practice.

I have been given a copy of your *Notice to Privacy Practices* (upon request) to review. I understand that you reserve the right to change the terms of this notice and I may contact you at any time to obtain the most current copy.

I understand that I have the right to request restrictions, in writing, on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name_____ Relationship_____

_____ _____
Patient Name Printed Patient Signature (Guardian if minor)

_____
Date

Mini Dental Implant Centers of America