Advanced

DENTISTRY

PATIENT CONSENT FORM

I understand that under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your ***notice of privacy practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***notice of privacy practices*** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of ***notice of privacy practices***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatments, payments or healthcare operations.

I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except in the extent that you have taken action relying on this consent.

Patient Name_____

Signature _____

Relationship to patient_____

Date_____

Advanced Dentistry, 9920 U.S Highway 90-A ste 100-C, Sugar land TX 77478