Health Insurance Portability and Accountability Act

I understand that I have certain rights to privacy regarding my/my child's protected health information. These rights were given to me/them under the Health Insurance Portability and Accountability Act (HIPAA). I understand by signing this consent I authorize you to use and disclose my/my child's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my child's treatment.
- Obtaining payment from third party payors (e.g. insurance companies).
- The day to day healthcare operations of your dental practice.

I have also been informed of and given the right to review and secure a copy of you/your child's *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my/my child's protected health information and my rights under HIPAA. I understand that you have the right to change this notice from time to time and that I may contact you at any time to request the most current copy of this notice.

I understand that I have the right to request restrictions on how my/ my child's 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 with written documentation you are bound to comply with the 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 revoked is not affected.

----------*Please sign and date below*----------

****By signing this form I acknowledge that the HIPAA information provided in this form is correct to the best of my knowledge***

_____ _____

Signature *Date*