HIPAA PRIVACY POLICY CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

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

I have also been informed of any given the right to review and secure a copy of your notice of privacy practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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

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

Signed this ________day of ________________, 2017

Print Patient Name ______________________________

Relationship to Patient: __________________________

Signature: ______________________________________

P.E.B. DENTAL DDS P A
155 STELTON ROAD
PISCATAWAY, NJ 08854
(732) 752-1932