1st Care DENTAL, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA – *Notice of Privacy Practice*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practice is to explain how *1st Care Dental, P.A.* may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Our notice of privacy practices is available for your review at the front desk.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the used and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

_____

Relationship to the Patient:

_____