JOSEPH
FAMILY DENTAL

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare 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 the right to read the *Notice of Privacy Practices* before deciding whether to sign this Consent Form.

This office reserves the right to change the privacy practices as described in the *Notice of Privacy Practices.* If it is changed, a revised *Notice of Privacy Practices* will be issued.

I have the right to request that you place additional restrictions on the use or disclosure of my health information. You are not required to agree to these additional restrictions, but if you do, you will abide by our agreement (except in an emergency).

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

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____