GAINESVILLE FAMILY DENTAL CENTER
HIPPA CONSENT FORM

SECTION A: PATIENT GIVING CONSENT

Patient Name: ____
Address: ____
Telephone: ____
Patient Number: ______________________________ SSN#:________________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this from you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities and healthcare operations.

Notice of privacy practices: 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 payment activities and health operation, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent.

We reserve the right to change our privacy practice as described in our Notice of privacy practices. Those changes may apply to any of our protected health information that we maintain.

Right to revoke: you have the right to revoke this consent at any time by giving us written notice to the extent the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

SECTION C: SIGNATURE:

I, ________________________________ have had the full opportunity to read and consider the content of this consent from and notice of privacy practices, I understand that by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment and health care operations.

Signature:____
Relation to patient: (self, parent, others)