

# PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected dental health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 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 by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (i.e. my insurance company).
- The day-to-day healthcare operations of your practice, such as:
  - Sending a recall appointment reminder to my home or email.
  - Leaving appointment, billing or dental information on my answering machine/voicemail/email
  - Giving permission to share appointment, billing or dental information with people at my contact address or contact telephone numbers.

I have also been informed of, and given the right to review and secure a copy if requested of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected dental 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 anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected dental health information is used and disclosed to carry out treatment, but that you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

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Signature of Patient

Date

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Printed Name of Patient

Self   Spouse   Parent/Guardian   Please Circle

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