PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected 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 Egidio Dental Care, P.C. to use and disclose my protected 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 Egidio Dental Care, P.C.

I have also been informed of and given the right to review and secure a copy of Egidio Dental Care, P.C. Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Egidio Dental Care, P.C. reserve the right to change the terms of this notice from time to time and that I may contact Egidio Dental Care, P.C. at any time to obtain the most recent 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 health care operations, but that Egidio Dental Care, P.C. is not required to agree to these restrictions. However, if Egidio Dental Care, P.C. does agree, we are then bound to comply with these restrictions.

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

Date: _____

Print Patient Name: _____ Patient's DOB: _____

Signature of Patient: _____ Relationship to Patient: _____

Egidio Dental Care, P.C.

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