Arlington Alexandria Endodontics

Root Canal Specialists
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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 you to use and disclose my protected health information to carry out:

-Treatment: We may use or disclose your health information to a physician or other healthcare providers providing treatment to you (e.g. your general dentist, a dental specialist, your primary care physician and/or other physician specialists involved in your care).

-Payment: We may use and disclose your health information to obtain payment for services we provide to you.

-**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations.

I have also been informed of and given the right to review and secure a copy of our *Notice of Privacy Practices* upon my request, which contains a complete description of the uses and disclosures of my protected 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 any time to obtain the most current 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 healthcare operations, but that we are not required to agree to these requested restrictions. However, if we do agree, that we are 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.

Signed this _____ day of _____, 20____.

Print Patient Name:_____

Relationship to Patient: _____

Signature: _____