General & Cosmetic Dentistry of Tampa

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HIPAA INFORMED CONSENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct a treatment plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please check box if you do not wish to receive text or email messages from this office.

☐ **I do not wish to receive text or email messages.**

I understand that I may revoke this consent in writing at anytime, except to the extent that you may take action relying on this consent.

Patient Name (print): _____

Signature: _____ Date: _____/_____/_____

Relationship to Patient: _____

PATIENT/RELATIVE CONSENT

I, _____, understand that by signing this Consent form, I am giving my consent to General & Cosmetic Dentistry of Tampa to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member:

Name: _____

Relationship: _____

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