HIPAA Patient 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 Dr. Conte to use and disclose my protected health information to carry out:

- Treatment (Including direct and 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 our practice.

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that the office reserves the right to change the terms of this notice from time to time and that patients may contact us 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 health care operations, but that Dr. Conte is not required to agree to these requested restrictions. However, if Dr. Conte does agree in writing, then he is bound to comply with this restriction.

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 date: _____

Print Patient's Name: First_____ Last _____

Relationship to Patient: _____

Signature: _____

INFORMED CONSENT TO PHOTOGRAPH

I, _____, do hereby give consent for Dr. Conte or staff to take and/or display photograph(s) of the face and teeth/smile of _____. The photograph will be used for educational and/or advertising purposes by Dental Excellence of Brandon and may be displayed within our office, advertisements or webpage, www.dentalexcellenceofbrandon.com. We will protect the patient's personal data, such as name, age and date of birth, from being displayed.

Print Name: _____ Signature: _____

Relationship to patient:

_☐_ Self _☐_ Guardian