Holehouse Center for Complete Dentistry, P.L.

3700 Winter Garden-Vineland Rd.
Winter Garden, FL 34787

PATIENT HIPAA CONSENT & ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

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 (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also acknowledge that I have also been informed of and given the right to review and secure a copy of your 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 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 have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

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 you are not required to agree to these requested restrictions. However, if you do agree, you are then 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.

Date signed _____.

Print Patient Name _____

Signature _____

Relationship to Patient _____

If Personal Representative signs on behalf of patient, print name: _____

Authority of Personal Representative to Sign for Patient (check one): □ Parent □ Guardian □ Power of Attorney □ Other

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written HIPAA Consent and Acknowledgement of receipt of our Notice of Privacy Practices by the individual noted above, but it could not be obtained because:

- ☐ An emergency prevented us from obtaining acknowledgement.
- ☐ A communication barrier prevented us from obtaining acknowledgement.
- ☐ The individual was unwilling to sign.
- ☐ Other:_____

_____ _____

Staff Member Signature Date