Angleton
Family Dental and Orthodontics

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent I authorize the office to use and disclose my protected health and personal information to carry out the following:

- ✓ **Treatment (including direct or indirect treatment by other health-care providers involved in my treatment).**
- ✓ **Obtaining payment from third party payers (e.g. my insurance company)**
- ✓ **The day-to-day health care operations of this practice.**

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 the practice is not required to agree to these requested 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.

_____
(Patient's Name Printed)

_____
(Patient/Legal Guardian's Signature)

_____
(Date)