HARPETH
—ENDODONTICS—

Patient 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 document I authorize Harpeth Endodontics to use and disclose my protected health information to carry out:

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

I have also been informed of and given the right to review and secure a copy of Harpeth Endodontics' *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 Harpeth Endodontics reserves the right to change the terms of this notice from time to time and that I may contact the office 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, and that Harpeth Endodontics is not required to agree to these requested restrictions. Requested restrictions must be provided in writing to our office, and Harpeth Endodontics will inform you on whether or not your request can be honored. I understand that I may revoke this consent, in writing, at any time and that revocation will be honored on the date it is received. Any use or disclosure that occurred prior to the date revocation is received does not affect this consent.

Printed Patient Name:_____

Patient/Legal Guardian Signature:_____

Relationship to Patient:_____

Date:_____/_____/_____