

PATIENT CONSENT FORM

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

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

I have been informed by Big City Dental of their 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 Big City Dental has the right to change its Notice of Privacy Practices from time to time and that I may contact Big City Dental 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 Big City Dental restricts how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that Big City Dental is not required to agree to my requested restrictions, but if Big City Dental agrees then Big City Dental is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Big City Dental has taken action relying on this consent.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____