MATTHEW ANDERSON DMD, MSD, INC

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how our office may use and disclose Protected Health Information (PHI) about you, the Patient. The Notice contains a Patient's Rights section that describes your rights under the law. You have a right to review our Notice before signing this Consent. The terms of our Notice may change. If a change is made, you may obtain a revised copy of the Notice by visiting our website or by directly contacting our office.

You have the right to request that we restrict how your PHI is used or disclosed for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI for treatment, payment, and healthcare operations. You have the right to revoke this Consent by submitting a signed, written request. However, such revocation shall not affect any discolsures we have already made in reliance on your prior Consent. Matthew Anderson, DMD, MSD, Inc. provides this form to you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice had a Notice of Privacy Practices and that the Patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information
- The Patient may revoke this Consent in writing at any time and all future disclosures will cease
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the Patient's behalf without this signed HIPAA consent form. Therefore, payment in full on the same day of service will be required for any treatment rendered

The following Patient has read this HIPAA Consent and, by signing below, acknowledges its receipt and agrees to consent to our use and disclosure of your Protected Health Information as outlined in the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Printed Name

_____

Date

_____

Signature of Practice Representative