ENDODONTIC ASSOCIATES OF GREATER WATERBURY

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 consent I authorize you to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

- **Treatment including direct or indirect treatment by other healthcare providers involved in my case.**
- **Payment: We may use and disclose your health information to obtain payment for services we provide to you.**
- **The day-to-day healthcare operations of our practice in relation to your treatment.**

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 periodically and that I may contact you at any time to obtain the most current copy of this notice.

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, then you are 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.

Signature: _____ **Date:** _____

Print Patient Name: _____

Relationship to Patient: _____