# PATIENT 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 this practice to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- 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 the practice 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 the office reserves the right to change the terms of this notice from time to time and that I may contact the office at anytime to obtain the most current copy of this notice.

I understand 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 that the office is not required to agree to these requested restrictions. However, if this practice does agree, we are then 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.

Other than myself, I give ________________________________ permission to discuss treatment, care and payment of my health record with the office of Vincent S. Campanino DDS, PC.

date: _______________________ , 2020

Name (please print): __________________________________
Signature: __________________________________________

If you are not the patient and are filling out this form on their behalf what is your relationship: __________________________________

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