



LG DENTAL
STUDIO

Patient HIPPA 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 Information Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you, LG Dental Studio, to use and disclose my protected health information to carry out the following:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)*
- *Obtaining payment from third party payer (e.g. My insurance company)*
- *The day-to-day healthcare operations of LG Dental Studio*

I have also been informed of a 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 HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the 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 health care operation, and that you 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 date I revoke this consent is not affected.

Signature of Patient _____ Date: _____

Print Patient's Name _____

Relationship to Patient _____