ELY FAMILY DENTISTRY

DR. SHERYL ELY

4140 NW 27TH LN. SUITE H

GAINESVILLE, FL 32606

HIPPA CONSENT FORM:

I understand that under the Health Insurance Portability & Accountability Act of 1996, 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 in-directly.

 Obtain payment from third-party payers.

 Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your “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 this organization has the right to change its “Notice of privacy Practices” from time to time and that I may contact this organization at any time at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_