**CONSENT for Use and Disclosure of Protected Health Information &**
**Notice of Privacy Practices Acknowledgement**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). The purpose of this consent is for ELIZABETH PATINO, DMD, PA's to use and disclose my PHI to carry out treatment, payment activities, and healthcare operations.

I have the right to read the Notice of Privacy Practices before deciding whether to sign this consent. The notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures that can be made of my PHI, and of other important matters about my PHI. The notice is posted in the reception counter, and I have being encouraged to read it carefully and completely before signing this consent.

I understand that Dr. Patino reserves the right to change her privacy practices as described in the Notice of Privacy Practices. If changed, a revision with the changes will be displayed. Those changes may apply to any of my maintained PHI.

I may obtain a copy of this form and/or the Notice of Privacy Practices, including any revisions.

I understand my right to revoke this consent at any time by submitting written notice to Dr. Patino.

I understand that revocation of my consent will not affect any action taken in reliance on my consent before this written notice of revocation has being received. I also understand that Dr. Patino may decline to treat me or to continue treating me after I have revoked my consent.

I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices and am bound to abide by such restrictions.

I understand that by signing this form I am giving consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

| ______________________________ | ___/___/____ | ____________________ | ___________________ |
|---|---|---|---|
| Signature of Patient<br>(or Parent/Guardian if minor) | Date | Printed Name | SS# |

***REVOCATION*** **of Consent for Use and Disclosure of Protected Health Information &**
**Notice of Privacy Practices Acknowledgement**

I *revoke* my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare options. I understand that revocation of my consent will not affect any action taken in reliance on my consent before this written notice of revocation has being received. I also understand that Dr. Patino may decline to treat me or to continue to treat me after I have revoked my consent.

| ______________________________ | ___/___/____ | ____________________ | ___________________ |
|---|---|---|---|
| Signature of Patient<br>(or Parent/Guardian if minor) | Date | Printed Name | SS# |