Intercoastal Endo
Mark Conard D.M.D., M.S.

HIPAA CONSENT FORM

Patient Consent for Intercoastal Endo to Use or Disclose Health Care Information for Treatment, Payment and Dental Care Operations

Patient's name _____ Date of birth_____

Social Security Number: ____-___-____

I understand that my health information is private and confidential. I understand that Intercoastal Endo. will work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Intercoastal Endo. may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. Failure to sign this consent may result in the dentist declining to treat me.

Intercoastal Endo has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices used to protect their patients' privacy. I understand that I have the right to read the "Notice" before signing this agreement. I understand that I may request a copy of this document while in the office, or there is a copy posted on www.intercoastalendo.com that I may download and keep as a personal file.

Intercoastal Endo may update this "Notice of Privacy Practices". If I ask Intercoastal Endo will provide me with the most current "Notice of Privacy Practices".

Under the terms of this consent, I can ask Intercoastal Endo to restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Intercoastal Endo does not have to agree to my request. If Intercoastal Endo does not agree to my request, I understand that Intercoastal Endo would follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel the consent, I understand that Intercoastal Endo may have already used or disclosed information about me, and canceling this consent would not effect the information already used or disclosed.

I may cancel this consent at any time by writing, signing, and dating a letter to Intercoastal Endo. If I write a letter, it must say that, I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations. I understand if I cancel this consent, Intercoastal Endo does not have to provide and further health care services to me.

My signature below indicates that I have been given the chance to review a current copy of Intercoastal Endo "Notice of Privacy Practices."

_____ _____

Patient or legally authorized individual signature Date

_____

Relationship to patient if signed by anyone other than the patient, (parent legal guardian, personal representative, etc.)