Intercoastal Endo
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HIPAA CONSENT FORM

Patient consent for intercoastal Endo to use or disclose Healthcare 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 healthcare to me, to handle billing and payment, and to take care of other healthcare 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 the 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 affect the information already used or disclosed.

I may cancel this consent at any time in 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 any 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".

Date _____

Signature _____
Patient or legally authorized individual signature

Relationship to Patient _____
(Parent Legal Guardian, Personal Representative, Etc.)