

Bao V. Nguyen, DDS, PA
Cindy N. Brayer, DMD
3388 49th Street North
St. Petersburg, FL 33713

HIPAA CONSENT FORM

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). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and continuation of care among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and communications with payers, physicians, dentists, and any other entity involved in my care, including family members and friends.

RESTRICTIONS to Personal Health Information:

I understand that I have the right to restrict access to my protected health information, and I have listed below the entities that I do not wish to authorize access:

Name(print)	Relationship	Specific Restriction Requested
Name(print)	Relationship	Specific Restriction Requested

Please write any additional restrictions on the back of this paper.

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

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 to obtain a current copy of this Notice.

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(print)	Signature of Patient or Parent/Legal Guardian (Identify relationship to patient)	Date
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