

# Periu Family Dentistry

## Patient Consent for Use and Disclosure of Protected Health Information

I understand that I have certain rights regarding the privacy of my protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I authorize Periu Family Dentistry to use and disclose my protected health information as necessary for the following purposes:

- **Treatment:** Providing and coordinating my dental care, including communication with other healthcare providers involved in my treatment.
- **Payment:** Obtaining payment for services from insurance companies and other third-party payers.
- **Healthcare Operations:** Conducting the day-to-day administrative and business activities necessary to operate the dental practice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, and healthcare operations. I understand that Periu Family Dentistry is not required to agree to my requested restrictions. If the practice agrees to a restriction, it will be required to comply with the agreed-upon restriction, subject to applicable law.

I understand that I may revoke this consent in writing at any time. However, revocation will not affect any use or disclosure of my protected health information that occurred before the revocation was received and processed.

### Patient Acknowledgment

By signing below, I acknowledge that I have read and understand this consent form and agree to the use and disclosure of my protected health information as described above.

Patient Name (Print): \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_