Periu Family Dentistry

650 Classic Court
Melbourne, FL 32940

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (insurance companies, etc.)
- The day-to-day healthcare operations of your practice

I understand that I have the right to request restrictions on how my protected health information issued and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I nay revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ Day of _____, 20___

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____