750 N Diamond Bar Blvd., Suite # 216, Diamond Bar, CA 91765
Phone: (909)860-3111
Fax: (909)860-3019
diamondbardental@verizon.net

PATIENT HIPAA 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 Diamond Bar Dental to 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 (example: insurance company, third party finance plan, etc).
- The day to day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of the practice *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that Diamond Bar Dental reserves the right to change the terms of this notice from time to time and that I may contact the practice at any time to obtain the most current copy of this notice.

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

I understand that I may revoke this consent in writing at any time. Any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Signature:_____

Date:_____

Relationship to patient:_____