TIMBERLANE FAMILY DENTISTRY

Thomas Salinas DDS

1972 N. Future Terrace
Lecanto, FL 34461

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 provider involved in my treatment);

*Obtaining payment from third party payers (e.g. my insurance company);

*The day-to-day healthcare operations for your practice.

I have also been informed of, and given the right to review and secure a copy of your 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 you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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

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

I understand my HIPAA rights and I request that this office leave messages, including those containing PHI, for me by voice mail or e-mail.

Please list by name any other people you are authorizing to receive your protected dental information.

_____

_____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____Date:_____

Signature:_____