Rock Doc Dentistry
Rene Herrera DDS

# HIPPA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan and direct treatment and follow-up 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 physician certifications.

I have been informed of the *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* and that I may contact this organization at any time at the email address listed below to obtain a current copy of the *Notice of Privacy Practices.*

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

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.

Email address for questions or more information: OCRPrivacy@hhs.gov

Patient Name: _____ Date: _____

Patient/Legal Guardian Signature: _____