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CONSENT FOR RELEASE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. These rights have been outlined in the Notice of Privacy Practices (NOPP).

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release the practice, its employees and agents for any and all disclosures as stated in the NOPP.

I understand that I may request in writing that you restrict how my private and super-confidential information is used or disclosed to carry out treatment and for payment of health care 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 restrictions.

I hereby authorize Stephanie Diaz, D.M.D. and her employees to use and disclose any necessary information from my dental record, verbally or by mail, email or fax in accordance with the Notice of Privacy Practices.

_____ _____

Print full Name **DATE**

_____

Signature

_____

Representative (if applicable)