Print Form

PATIENT CONSENT FORM

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

* Conduct, plan and direct my 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 by you of your 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 from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice off 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 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 understand that I may revoke this consent in writing at any time, except that you have taken action relying on this consent.

☐ OK to discuss treatment or payment with immediate family members

☐ OK to leave messages on answering machine/voice mail

Patient Name: _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____

DOUGLAS DENISON, D.M.D.,PA 2430 S.ATLANTIC AVE. SUITE D, DAYTONA BEACH SHORES,FL 32114