

# HIPAA Consent Form

I understand that, under the Health Insurance and Portability 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 to obtain a current copy of the Notice of Privacy Practices at the address of:

**11872 Sunrise Valley Drive, Suite 100  
Reston, VA 20191**

I understand that I may request in writing for you to 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 anytime, except to the extent that you have taken action relying on this consent.

I agree that you may release my personal health information to:

\_\_\_ Dental/health insurance companies

\_\_\_ My spouse

\_\_\_ Other. Please list name(s) \_\_\_\_\_

\_\_\_\_\_

In addition to the above mentioned rights, I understand that my medical and dental information may be disclosed ONLY for the purpose of providing, coordinating, or managing health care related services. This authorization will remain in effect until I submit a written revocation to:

**Frank J. Dunne, D.D.S.**

Printed Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_