Advanced Endodontics

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and 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 **Advanced Endodontics**, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time at 14595 Bel-Red Road, Suite 103, Bellevue, Washington 98007 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 health care operations. I also understand that you are bound to abide by such restrictions.

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.

I authorize Advanced Endodontics Inc. to leave messages for me on my voicemail at home or at work regarding my visit and treatment.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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