HIPAA Patient Consent Form

I understand that I, or my child, have/has certain rights to privacy regarding my/his/her protected health information. These rights are given to me/him/her under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize Gandy Orthodontics, Dr. Allen Gandy and his employees to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Payment collection from third party payers (i.e. insurance companies)
- The day to day healthcare operations of the practice.
- Educational and demonstrational activities.

I have also been informed of, and given the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of protected health information, and my/my child's rights under HIPPA. I understand that Gandy Orthodontics, and Allen Gandy D.D.S, M.S. reserves the right to change the terms of this notice from time to time and that I may contact Gandy Orthodontics, and Allen Gandy D.D.S, M.S at any time to obtain a more current copy of this notice.

I understand that I have the right to request restrictions on how my or my child's protected health information is used and disclosed to carry out treatment, payment, health care operations, and educational and demonstrational activities and that Allen Gandy D.D.S., M.S. is not required to agree to these requested restrictions. However, if Allen Gandy D.D.S., M.S. agrees to these restrictions, it is bound to comply by them.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____ day of_____, 20_____.

Signature of Responsible Party: _____

Printed Name of Responsible Party:_____

Relationship to Patient: _____

Printed Patient Name: _____