Ramin Azghandi, DDS, PA
Periodontics & Implants

Notice of Privacy Practice Consent
(HIPAA)

Please Print Patient Name:_____

Our notice of privacy practice consent provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form the patient consents to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a notice of privacy practices and that you have had the opportunity to review this notice.
- The Practice reserves the right to change the notice of privacy practices.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this consent.

My signature below indicates that I have read and understand this consent in its entirety, that my questions have been adequately answered, and that I have received a copy of the notice of privacy practices.

Name of Responsible Party:_____
Please Print

Relationship to Patient: _____
Please Print (Self, Parent, Lawful Guardian)

_____
Signature *Date*

_____
Witness *Date*