

## **PATIENT CONSENT FORM**

**JEFFREY M. DRESSEL DDS PC**

**62 2<sup>nd</sup> PLACE**

**BROOKLYN, NY 11231**

I understand, that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy information that 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 the treatment directly or 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 above 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 you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide of 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.

**PATIENT NAME:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_