Dental Expressions P.L.
5050 Tamiami Trail North Suite A
Naples, FL 34103

Dental Expressions Of Fort Myers L.L.C.
3230 Forum Blvd. Suite 501
Fort Myers, FL 33905

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice Of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SECTION A: PATIENT GIVING CONSENT

NAME: ____

ADDRESS/CITY/STATE/ZIP: ____

TELEPHONE: ___________________________ E-MAIL: ______________________________

SOCIAL SECURITY NO.: ______________________

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Our commitment to your privacy: Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare options, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.
Right to Change: We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices we will issue a revised Notice of Privacy Practices, which contain the changes. Those changes may apply to any of your protected health information that we maintain.
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person(s) listed below. Please understand revocation of this consent will not affect any action we took in reliance

You may obtain a copy of our Notice Of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person (s): Peyul Patel - Senior Office Manager
Address: 5050 Tamiami Trail North-Suite A, Naples, FL 34103
Telephone: (239) 262-6364 Fax: (239) 262-7970
E-Mail: peyul@mydentalexpressions.com

I, __________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice Of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities & health care operations.

Signature: ______________________________________ Date: ________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representative's Name: ___________________________________ Date: __________________

Relationship to Patient: ____