PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 19916 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information.

- TREATMENT (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining PAYMENT from third party payers, such as my insurance companies and me, your patient;
- The day-to-day HEALTHCARE OPERTATONS of your practice.

I have also been informed of, and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how to my protect health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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.

Print Patient Name:_____

Signature:_____Relationship to patient:_____

Date:_____

Barksdale and Hastings DDS
2606 A Bens Branch Drive
Kingwood, TX 77339