Lumberton Dental Center, P. A.
P.O. Box 8239
Lumberton, Tx. 77657
409-755-3666

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me understand that by signing this consent I authorize you 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);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-today healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *NOTICE OF PRIVACY PRACTICES*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this 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 my protected health information is used and disclosed to carry out treatment, payment and health care 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 have the right to refuse consent to the use or disclosure of my personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

I give Lumberton Dental Center permission to release/discuss my dental care or financial needs to the following:

1. ____relationship: _________________
2. ____relationship: _________________
3. ____relationship: _________________

By filling this form out and signing it I understand that this document is in effect until I request a change.

Signature: ____**DATE:**____________________

Print Patient Name: ____ **Relationship:** __________________