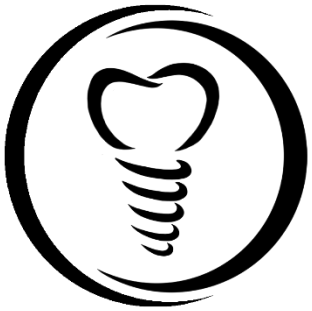

FAMILY, IMPLANT & COSMETIC DENTISTRY

Fadi Raffoul, D.M.D. | Sanford Schwartz, D.D.S.

CREATING BEAUTIFUL SMILES SINCE 1979

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 1996 (HIPAA). I 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-to-day 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 Practice*, 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 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 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 may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this _____ day of _____, 20____.

_____ _____

Print Patient Name | Relationship to Patient

_____ _____

Signature | Doctor or Staff

HIPAA Patient Questionnaire

1. Please list the family members or other person, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   _____

   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name: _____Phone Number: _____
Name: _____Phone Number: _____
Name: _____Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

   _____

   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

   Yes:_____ No:_____

5. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results or other health care information if other than your home phone number:_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail?

   Yes:_____ No:_____

7. I understand the Privacy Protection Act.

PATIENT NAME:_____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE