DAVID D. HAYES, D.D.S.

Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Contract, plan, and direct my treatment and follow-up care among healthcare providers who may be involved in my treatment directly or indirectly.
2. Obtain payments from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Dr. Hayes' office of the *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 my 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 Dr. Hayes' office at any time at the address listed to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Dr. Hayes' office restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Dr. Hayes' office is not required to agree to my requested restrictions. If Dr. Hayes' office does agree to my request, then Dr. Hayes' office is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Dr. Hayes' office has taken action relying on this consent.

Signature:_____Date: ____-____-____

Printed Name:_____

Relationship to patient (if a minor):_____