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Consent for Use and Disclosure of Health Information

I hereby understand that I have certain rights to my privacy in regards to my protected health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs these rights. It is important for me to understand that the use of my health information be available for use by this office to accomplish three goals:

- Providing treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers such as insurance companies
- Running day-to-day healthcare operations of this practice.

I am hereby informed that I have the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more detailed description for the uses and disclosures of my health information. Should the terms of this form be modified in any way as necessary by this office, a copy of it is available for my records.

I understand that it is my right to request restrictions on how my protected health information is used and disclosed to fulfill treatment, payment and or healthcare operations, but that we are not required to comply with these restrictions. However, if we do agree to such request, we are bound under HIPAA to comply with the restrictions.

This consent hereby goes in effect upon the signing date of this form and will continue to such time unless revoked by myself in writing at any time. Any use or disclosure that occurred during this period is not affected by any outcome in which I have revoked this consent.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____