Lee D. Tatro, DDS
923 W. Dixie Ave
Leesburg, Fl 34748

HIPAA PRIVACY POLICY ACKNOWLEDGEMENT FORM

I understand that I have certain rights regarding my privacy 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 (i.e. my insurance company, if applicable)
- The day to day healthcare operation 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 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. You are not required to agree to these requested restrictions however, if you do agree, we are both bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred to the date I revoke this consent is not affected.

If you would like to give our office permission to share your health information with anyone other than your spouse please let us know.

Signed this_____day of_____, 20_____

Patient's Name (Printed)_____

Signature_____

Relationship to patient_____