Ocala Dental Care
OCALA DENTAL IMPLANT CENTER

HIPAA Acknowledgement

I understand I am giving my full consent to use and disclose my personal protected health information to carry out the following:

* Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
* Payment activities and health care operations including preparing insurance forms via the internet or mail and third party finance companies

No information is sold for marketing purposes. I understand and have read the Notice of Privacy Practice used by Ocala Dental Care (given upon request) or am familiar with the HIPAA privacy practices required by the State of Florida. This form shall remain in effect indefinitely or until I revoke by written notice.

Print Patient Name: _____

Patient Signature: _____

Date: _____ Guardian Name (if applicable):_____

I have authorized the following individual(s) to have access to my Protected Health Information

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____Phone: _____

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