SPECIALISTS IN IMPLANT DENTISTRY

HIPAA

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to Dr. Matthew J. Holtan using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand upon request that I will be provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Dr. Matthew J. Holtan reserves the right to change our notice and information practices and that I may obtain a copy of the revised notice by written request addressed to Melissa Stadler, C/O Dr. Matthew J. Holtan, 12052 Tamiami Trail N., Naples, FL 34110.

I understand that I have the right to restrict how Dr. Matthew J. Holtan uses or discloses my protected health information to carry out treatment, payment, or health care operations; that Dr. Matthew J. Holtan is not required to agree to the restrictions and the Dr. Matthew J. Holtan is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

_____

_____

_____

I request the following be allowed access to my protected health information to carry out treatment, payment, or health care operations: _____

_____

_____

I have the right to revoke this consent by notifying Dr. Matthew J. Holtan in writing, except to the extent that Dr. Matthew J. Holtan has taken in reliance on my consent.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient or Representative's authority To act on the patient's behalf