

**PATIENT CONSENT TO DISCLOSE
PRIVACY ACKNOWLEDGE**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use, disclose and release my protected health information and/or x-rays to carry out:

- Direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (e.g., my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice Privacy Practice, which contains a more complete description of uses and disclosures of my protected health information and my right 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 healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I grant Centre Smiles permission to share my protected health information with the following persons listed, I understand that I may revoke this permission at any time by written request.

Printed Name(s)/Phone Number (if multiple, please separate individuals by using a comma)

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

Printed Names of Minor Children (those to be covered under this release)

Printed Patient Name

Signature of Patient or Responsible Person

Date