HIPPA CONSENT FORM

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure For Treatment, Payment, and Operations

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice. I consent and agree that in connection with any billing inquiry or payment matter, we may disclose healthcare information relating to the services and claim at issue to the financial institution, entity, credit card company, or insurance company reviewing the issue.

By signing below, I hereby consent and agree that Hugh M. Musof, D.M.D. may disclose information regarding my healthcare, including information regarding my appointments (date, time), prescription information or other requested information to the following family members or other specified individuals.

Please list individuals' names and their relationship to you:

Name	Relationship to You
_____	_____
_____	_____
_____	_____

I understand that I may revoke this consent at any time, in writing and deliver to:
Hugh M. Musof D.M.D.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative (Including description of legal authority)

Date