WINDERMERE CENTER FOR DENTISTRY

401 Main Street, Suite A
Windermere, FL 34786

HIPPA CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPPA)**, I have certain rights to privacy regarding my protected health information.

We will use your **HEALTH INFORMATION** within our office to provide you with the best dental care possible. Please understand that this information will be used to:

- Conduct administrative and clinical office procedures in order to optimize the scheduling and coordination of care between hygienist, dental assistant, dentist and business office staff.

- Conduct, plan and direct your treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.

- Obtain payment from third party payers.

We want you to know that we have developed procedures and policies to make sure your health information will **not** be shared with anyone who does not require it.

Thank you very much for taking the time to review how we are carefully using your health information. If you have any questions please feel free to ask us.

Patient
Names(s): _____

Signature: _____

Date: _____