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. John and Dr. Samuel Cancelliere using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand 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. John and Dr. Samuel Cancelliere reserve 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 John P. Cancelliere C/O The Dentistry in Naples, 1001 Crosspointe Drive, Suite 2 Naples FL 34110.

I understand that I have the right to restrict how Dr. John and Dr. Samuel Cancelliere uses or discloses my protected health information to carry out treatment, payment or health care operations.

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

FAMILY or FRIEND NAME ________________________ If no one please write" no one" and initial _____

I have the right to revoke this consent by notifying Dr. John and Dr. Samuel Cancelliere in writing, except to the extent that Dr. John and Dr. Samuel Cancelliere 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