Anthony S. Nguyen, DMD, PS
8019 Aurora Ave N
Seattle, WA 98103

HIPPA Consent

for Use and Disclosure for Treatment, Payment & Healthcare Operation

Patient Name____Date_________________

Section A: Consent

I hereby consent for the use or disclosure of my individually identifiable health information to carry out treatment, payment and/or health care operations. This includes assignment of benefits. This consent is authorized for Green Lake Dentistry and/or Anthony Nguyen, DMD and/or his representatives.

Section B: Patient Rights: Initials

- I have the right to revoke this consent except to the extent that the Provider had taken action prior to the revocation. ___________
- I understand that this authorization if voluntary ___________
- I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment or healthcare operations and that the provider is not required to comply with requested restrictions. ___________

List Requested Restrictions (if any):

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(Patient's or Patient's Representative's Signature)

Section C: Revocation of Consent

I revoke my consent for use of my Patient Health Information for treatment, payment and/or health care operations effective___________________, 20_____.

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(Patient's or Patient's Representative's Signature)