Infinity Dental
8940 W. Tropicana Ave
Las Vegas, NV. 89147
702-248-4448

HIPAA Privacy Act

Patient Name: _____ Date of Birth: _____

Posted in our lobby is our *Notice of Privacy Practices*. It provides information about how our office may use and disclose your Protected Health Information (PHI).

You have the right to review our *Notice of Privacy Practices* before signing this patient consent form. Please take time to do so no. A copy is attached.

You have the right to request that we restrict how your PHI is used or disclosed for treatment, billing/payment, or dental office operations. Request for Restriction of PHI must be submitted to the OCP in writing and signed by you as specified in our notice. (Our office does not have to agree with you Request for Restricted PHI. If we agree to your Request of Restriction of PHI we shall honor that agreement.)

You have the right to revoke this Patient Consent Form. Revocation of Consent must be submitted to the OCP in writing and signed by you as specified in our Notice. (A Revocation of Consent does not affect disclosures made prior to the date the Revocation was made.)

Our *Notice of Privacy Practices* may change from time- to- time. If it does, you will receive a revised notice on the first visit after the changes were made.

Your signature below signifies your consent to the use and disclosure of your personal health information by our office during treatment, billing/payment and dental office procedures as outlined in our Notice. Our office may condition dental treatment upon execution of this Patient Consent Form. This form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

X_____ Date: _____

Patient/Guardian Signature

X_____

(Print Name)