MILLENNIUM ENDODONTICS

HEALING WITH A GENTLE TOUCH

Consent for use or Disclosure of Information: HIPAA

- I hereby permit Millennium Endodontic to use my health information, and/or to disclose my health information to any third party listed on the Notice of Privacy Practices form.
- I understand that there is a Notice of Privacy Practice posted in the reception room area, available for me to read.
- This consent shall be in effect in force and effect as long as I am a patient of Millennium Endodontic.
- I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my doctor(s) at this practice.
- I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO:

- **Inspect** or copy the protected health information to be used or disclosed as permitted under federal law. (Or state law to the extent the state law provides greater access rights)

- **Refuse** to sign this consent form or disclosure.

_____

Signature of patient or personal representative Date

_____

Name of representative patient or personal

_____

Description of personal representative's authority

_____

I hereby refused to sign this consent form Date