Randazzo Dentistry
2300 Robious Station Circle
Midlothian, VA 23113
804-897-2900

NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose any protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice
- Permission to leave messages on voicemail

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

By signing this paper below, I give permission to the person(s) listed below to receive Protected Health Information:

Date	Name of Individual
_____	_____
_____	_____
_____	_____

Please Initial _____ I give permission to the office to leave messages on my voicemail.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____,20_____

Patient Name: _____

_____

Signature of Patient/Parent/Guardian