BRIDGEWORKS
FAMILY DENTAL CENTER
"Over 25 Years Of Modern Dentistry"

Vincent Antonelli, DDS
Ted Malahias, DDS
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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 (HIPAA).** I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. To release Dental/Medical information to other dental/medical providers, when necessary, for your treatment.
2. To release Dental/Medical information to insurance companies.
3. To process all insurance claims if applicable.
4. Obtaining payment from third party payers (e.g. my insurance company).

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree you are then bound to comply with this restriction.

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.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

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