Bella Dente Fine Dentistry

13650 West Colonial Suite 120-A
Winter Garden Florida 34787
Tel: (407) 905-5698 Fax: (407) 905-0513

HIPPA CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

This notice summarizes how medical information about you may be used and disclosed. The complete NOTICE OF PRIVACY PRACTICES of Bella Dente Fine Dentistry is available if you need one.

Bella Dente Fine Dentistry will use medical/dental information for the following:

1. TREATMENT: Including your records to consulting dental specialists and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your dental record to pay the claim.
3. HEALTHCARE OPTIONS: Any others involved in your dental care.

To protect your privacy and in conjunction with our policy please provide us with the following information and authorizations:

1. Name of person or persons we may speak to regarding your health (i.e. spouse, child, etc). Notice of Privacy Practices.

_____	_____
Name	Phone Number
_____	_____
Name	Phone Number
_____	_____
Name	Phone Number

2. May we leave a message and/or text regarding your health or an upcoming appointment on your answering machine or voicemail?

   YES____ or NO_____.

3. I acknowledge that I have the opportunity to review a copy of the Notice of Privacy Practices with the effective date 04/14/03. Such copy may be obtain at the front desk.
4. I authorize the release of protected health information to my insurance company only to the extent necessary to obtain payment for services rendered.

Signed:_____ Date: _____

Print Name: _____ Date of Birth: _____

Witness: _____