All American Smile Dental Studios

161 Madison Avenue
New York, NY 10016

624 Kings Highway
Brooklyn, NY 11223

PATIENT CONSENT FORM

1. I acknowledge that I have read a copy of the Practice's "HIPAA Privacy Notice" which describes the Practice's obligation to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care operations. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

2. Further acknowledge that the Practice can change its HIPAA Privacy Notice in the future.

3. I understand that the right to request that the practice restrict its uses and disclosure of my health information for treatment, payment or health operations. If my restrictions are accepted by the practice, these restrictions will be binding on the practice. I also understand that the Practice is not required to agree to my request restrictions.

4. I do not request any restrictions on the Practice use and disclosures of my health information for treatment, payment or health care operations. _____Initial.

5. By signing this form, I consent of the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the practice has already taken in reliance on this consent.

_____ _____
Signature of Patient or Patient's representative Date

THIS FORM MUST BE READ BEFORE SIGNING.