Endodontic Associates of Greater New York

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

THIS FORM IS NECESSARY IN ORDER TO COMPLY WITH THE HEALTH INSURANCE APROBABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

By my signature below, I hereby acknowledge receipt of this notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me,and conducting health care operations.

I have also been advised of my rights to obtain access to control my Protected Health Information.

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Signature of Patient or of personal Representative, or Parent/Guardian	Date