HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
DENT NEUROLOGIC INSTITUTE
Acknowledgement of Receipt of Privacy Notice
And Restrictions/Permissions

A copy of DENT Neurologic Institute's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state laws has been made available to me.

I understand the contents of the Notice and I request the following exceptions:

RESTRICTIONS:

Please restrict the use and disclosure of my protected health information as follows:

_____

_____

_____

_____

PERMISSIONS:

I give permission to the following individuals to view, discuss, exchange, and/or receive my protected health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize DENT Neurologic Institute and the DENT Neurosciences Research Center (DNRC) to access my health data and use my protected health information for clinical research purposes.

_____ **Yes**, DENT and DNRC may use my information to conduct clinical research.

Initial Here

This notice and consent will remain in effect until revoked in writing.

Patient Name (print): _____ DOB: _____

Patient Signature: _____ **Date:** _____

If signed by a person other than the patient, please indicate relationship: _____

NOTE: Power of Attorney and Legal Guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.