HIPAA NOTICE OF PRIVACY PRACTICES
THE BRACE PLACE
DAVID L. LEEVER, D.D.S
9806 NORTH 56TH STREET
TEMPLE TERRACE, FLORIDA 33617

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with the respect to protect health information.

I, the undersigned, understand that as part of my healthcare, Dr. Leever originates and maintains paper and/or electric records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as

A basis for planning my care and treatment
A means of communicating among the many health professionals who contribute to my care
A means by which a third party payer can verify that services billed were actually provided.

I understand and have been provided with a NOTICE OF PATIENT PRIVACY INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following right and privileges:

The right to review the notice prior to signing this consent
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I wish to have the following restrictions to the use of my health information.

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May we leave an appointment reminder at home using the doctor's name? Yes ( ) No ( )
May we leave an appointment reminder at work using the doctor's name? Yes ( ) No ( )
Do not leave a message ( )
Please tell us with whom we may discuss your treatment, payment, or healthcare:
Example: Names of spouse, children, other relatives, friends or caregivers

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I fully understand and accept the terms of this consent

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Patient's Name Parent's Name (if patient is minor) Date