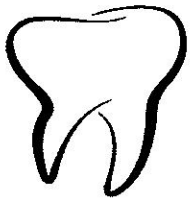

ANNETTE C. THEOFILOS, D.M.D.

HIPPA COMPLIANCE

As required by the **Health Insurance Portability and Accountability Act** of 1996(HIPPA) this practice may use your personal health information for the purposes of treatment, payment, or healthcare operations only. The specific uses and disclosures that we intend to make are described in our privacy policy. You have the right to review our privacy policy prior to signing this consent form. You may request restrictions on the uses and disclosures described in the privacy policy by describing the requested restrictions in the "Restriction Request" section of this form.

CONSENT SECTION

I, _____, hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. My signature below indicates that I have been given the opportunity to review the privacy policy of Annette C. Theofilos, D.M.D./ACT dental Inc.

Please allow the following person(s) to obtain my healthcare information. (If none, write "none")

_____ _____

_____ _____

RESTRICTION REQUEST SECTION

I hereby request the following restrictions on the use and disclosure of my health information. (Please describe in detail)

_____

_____

_____

_____

Patient Signature_____Date_____