

Health Insurance Portability and Accountability

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health and dental information. I understand that this information can and will be used:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment.

Obtain payment from third party payers. (Insurance Co.)

Conduct normal healthcare operations such as quality assessments.

Allow our office to release patient records to schools, Insurance Companies, and any other healthcare providers.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my dental information prior to signing this consent. I understand that this office, Kelly Hollis D.D.S.,P.C. has the right to change the Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing how my information is used or disclosed to carry out treatment and payment. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on this consent.

Patient Name: _____

Signature: _____

Relationship to patient: _____