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 or 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: ________________________________

Information Sharing: (Please list any individuals we can share your personal information with other than healthcare providers:

NAME: **RELATIONSHIP:**
PHONE:

____