PATIENT HIPAA WARENESS

With my permission, K.I.S.S. Dental Care may use and disclose protected health information (PHI) about me to carry out treatment, payment and health operations (TPO). Please refer to K.I.S.S. Dental Care's Notice of Privacy Practices for a more complete description of such use and disclosers.

I have the right to review the Notice of Privacy Practices prior to signing this consent. K.I.S.S. Dental Care reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of K.I.S.S. Dental Care may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results.

With my permission, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements may be mailed to my home or other designated location. I have the right to request that K.I.S.S. Dental Care restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am allowing K.I.S.S. Dental Care to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosers in reliance upon my prior consent.
I acknowledge that I have read this statement and agree to the contents.

Signature of patient, or guardian (responsible party)

Signature:_____ **Date:**_____