

Due to the **Health Insurance Portability and Accountability Act**, our privacy policy is now available to our patients. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office waiting room for patient's review. Your signature is your acknowledgement of this HIPAA policy.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our *Notice of Privacy Practices* before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have had the opportunity to read and consider the contents of this consent form and Kaufman Family Dentistry’s Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to Kaufman Family Dentistry’s use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_

**Thank you for your cooperation in complying with the Federal HIPAA Regulations. This privacy of your health information is important to us. At your request, we will be happy to provide you with a copy of this consent form.**