HIPAA Patient Notice of Privacy Practices and Consent

I have been given this office's Notice of Privacy Practices that explains how my medical information may be used and disclosed.

I hereby authorize you to use any and all of the information described below to conduct. plan, or direct my treatment among the multiple healthcare providers and my insurance carrier.

This consent will include the following information:

1. Treatment notes and letters
2. Radiographs (x-rays)
3. Clinical photographs
4. Request for Medical Consult from physician and or dentists, as required
5. Latest insurance coverage information, if applicable
6. Discuss Post treatment instructions or treatment options with any other person you identify that is
   involved in your dental care or financial obligation.
7. Contact you and or leave messages at home phone, cell phone (text messages) and or email
8. Mail out appointment reminders and or any other information pertaining to this office.

I understand that in some limited situations my information may be used without my consent.

1. As required by law
2. For public health purposes

Print Name	Signature	Date