HIPAA ACKNOWLEDGEMENT
CONSENT OF DISCLOSURE

(For the Usage and or Disclosure of Protected Health Information)

KILLEEN FAMILY DENTISTRY PRIVACY AND CONSENT

1. I authorize the doctor/staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my/the patient's dental needs.
2. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor/staff, and to use the appropriate medication and therapy indicated for such treatment.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor can choose and employ such assistance as deemed fit to provide recommended treatment.
4. I have answered all the above questions to the best of my knowledge. If there have been any changes to my insurance, health or medication, I have and/or will inform my dentist during my next appointment.

I, the undersigned, hereby authorizes that I have read, understand and agree to the above conditions.

Patient Signature:_____ Date:_____

Parent/Responsible Party:_____ Date:_____

I hereby give consent to **KILLEEN FAMILY DENTISTRY** to use and disclose my protected health information for the purpose of treatment, payment and health care operations.
You may cancel this consent at any time. Your cancellation must be in writing, signed and delivered to the address below. You may deliver this in person or by mail but it will only be effective when we receive it.
You have the right to request restriction on the usage and disclosure of your health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.
Our Posted Privacy Policy provides more detailed information about the usage and disclosure for your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.
We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy be requesting it from the front desk staff.

I have had an opportunity to review the Notice of Privacy Practices.

Print Name of Patient _____

Signature _____ Date _____

Parent or Guardian of Patient (if applicable)

Print your Name _____

Relationship _____

KILLEEN FAMILY DENTISTRY
3300 E. CENTRAL TX EXPY SUITE 302, KILLEEN, TX 76543
PHONE: (254) 699-6799, FAX (254) 699-3465