

## **Kocher & Kocher Dentistry**

### **HIPAA Consent Form**

For purposes of treatment, payment and healthcare operations

I, \_\_\_\_\_, consent to the use of disclosure of my protected health information by Kocher & Kocher Dentistry, for purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kocher & Kocher Dentistry. I understand that diagnosis or treatment of me by Kocher & Kocher Dentistry, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Kocher & Kocher Dentistry is not required to agree to the restriction that I request, the restriction is the binding on Kocher & Kocher Dentistry and the healthcare provider.

I have the right to revoke this consent, in writing, at any time, except to the extent that the healthcare provider or Kocher & Kocher Dentistry has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my healthcare provider, another healthcare provider, a health plan, my employer or a health care clearing house. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or is reasonable basis to believe the information may identify me.

I understand I have a right to review Kocher & Kocher Dentistry's Notice of Privacy Practices Prior to signing this document. Kocher & Kocher Dentistry's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kocher & Kocher Dentistry is also posted in the office waiting area. This Notice of Privacy Practices also describes by rights and Kocher & Kocher Dentistry's duties with respect to my protected health information.

Kocher & Kocher Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requested a revised copy by sent in the mail or by asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative