KENT ISLAND
PEDIATRIC
DENTISTRY

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Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

Patient Name: _____ Date: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Kent Island Pediatric Dentistry may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Kent Island Pediatric Dentistry has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Kent Island Pediatric Dentistry will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Kent Island Pediatric Dentistry to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Kent Island Pediatric Dentistry has taken action relying on this consent.

Signature (Parent or Legal Custodian/Authorized Representative)

_____

Date _____

Relationship to Patient (if signed by another party)_____

You may obtain a copy of our *Notice of Privacy Practice,* including any revisions of our '*Notice*' at any time by contacting: Kent Island Pediatric Dentistry (410) 604-2211