



## Family Dental Center

10 IBM Road, Suite C&D

Poughkeepsie, NY 12601

(845) 463-9300

Fax (845) 463-3035

### PATIENT HIPAA AWARENESS

With my permission, Family Dental Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Family Dental Center Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Family Dental Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Family Dental Center may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results, among others.

With my permission, the office of Family Dental Center may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. This also includes texting appointment reminders.

With my permission, the office of Family Dental Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Family Dental Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Family Dental Center to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Date