TENNESSEE RIVER
DENTAL

HIPAA Acknowledgement/Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Tennessee River Dental, PLLC, to use and disclose any protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of Tennessee River Dental, PLLC

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Tennessee River Dental, PLLC reserves the right to change the terms of this notice from time to time and that I may contact them at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Patient Signature Date

_____
Printed Name

_____ _____
Guardian Signature (if patient is under age 18) Relationship to minor