Fredericksburg Dentistry, PLLC
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814 South Milam Street
Fredericksburg, Texas 78624

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, both directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been informed by this office of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review the *Notice of Privacy Practices* before signing this consent form. I understand that this office has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this office at any time, at the above address, to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request, in writing, that this office restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this office is not required to agree to my requested restrictions, but if it does agree, then this office is bound to abide by such restrictions.

I understand that I may revoke this consent, in writing, at any time, except to the extent that this office has taken actions relying on this consent.

Patient Name:_____

Relationship to Patient (if other than patient):_____

Signature:_____ Date:_____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgment of reading the Notice of Privacy Practices in the Dental Office, but was unable to do so as documented below.

Date:_____ Initials:____ Reason:_____