Hoeg Dental Group

Health Insurance Portability Act Acknowledgement Form (HIPAA)

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 Charles R Hoeg DMD PC and Hoeg Dental Group to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatments)
- Obtaining payment from third party payers on my behalf (e.g. my insurance company)
- The day to day healthcare operations of the Hoeg Dental Group

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 Hoeg Dental Group reserves the right to change the terms of this notice from time to time and that I may contact Hoeg Dental Group at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Hoeg Dental Group is not required to agree to these restrictions. However, if Hoeg Dental Group does agree, they are bound to comply with these restrictions.

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.

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Print Patient Name Relationship To Patient

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Signature Date