Horvath Family Dentistry

We Love to Make You Smile

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION, HEALTH INSURANCE AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for Horvath Family Dentistry (HFD) to use and disclose protected health information about me to carry out treatment, payment and health care operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. HFD reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Horvath Family Dentistry, 734 West Ingomar Road, Pittsburgh, PA 15237.

With this consent, HFD may call my home, mobile or other alternative location and leave a message on the voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or other health care operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, HFD may mail to my home, or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Person and Confidential."

With this consent, HFD may E-mail to my home or other alternative 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 HFD restrict how it uses of discloses my protected health information (PHI) to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Horvath Family Dentistry to use and disclose my PHI to carry out 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. If I do not sign this consent, or later revoke it, HFD may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date

Dr. Kristin Horvath, D.M.D.

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www.horvathfamilydentistry.com