MAJESTIC
DENTAL

27030 Kuykendahl Rd Suite 160 Tomball, Tx 77375

PATIENT ACKOWLEDGE OF HIPAA PRIVACY PRACTICE

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 you to use and disclose my 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 (e.g., my insurance company)
- The day-to-day healthcare operations ofyour practice.

I have also been informed of and given the right to review and secure a copy of your Noticeof Privacy Practices, which in a more complete description ofthe uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms ofthe notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restriction how my protected health informationis used and disclosed to carry out treatment, payment and healthcare operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

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 provoke this consent is not affected.

SIGNED THIS _____DAY OF _____,20_____

Patient Name: _____

Relationship to patient (e.g. self, mother, father): _____

Signature of Patient or Guardian: _____