# Kutina Dental Office

## *HIPAA Privacy Authorization Form*

I acknowledge that I have received a copy of the Kutina Dental Office's Notice of Privacy Practices effective November 1, 2018.

| ______________________________ | ________________ | ______________________ |
|---|---|---|
| (signature of patient/patient representative) | (Date) | (relationship to patient) |

I acknowledge that I have received a copy of Kutina Dental Office's Rights and Responsibilities of Patients and the Grievance Process form.

| ______________________________ | ________________ | ______________________ |
|---|---|---|
| (signature of patient/patient representative) | (Date) | (relationship to patient) |

### ***Persons involved in Care or Payment For Care***

Kutina Dental Office may disclose my protected health information ( including scheduled/rescheduled appointments, test results, diagnoses, treatment plan, billing questions, etc.) to the following people in my care or payment for my care. *If you decline to give such permission, leave the following blank.*

**Spouse:**______________________________ **Phone #:**________________

**Child(ren):**______________________________ **Phone #:**________________

**Parent(s):**______________________________ **Phone #:**________________

**Other:**______________________________ **Phone#:**________________

### ***Communications***

Kutina Dental Office may communicate with me as follows about my appointments, test results, treatment options, breach notifications, or any other matter related to my treatment or payment for my treatment. Please answer all questions below by circling either "Yes" or "No" and at least one must be circled "Yes".

| | | |
|---|---|---|
| YES | NO | By calling me at my home phone number______________________ |
| YES | NO | By leaving messages on my home answering machine/ voicemail |
| YES | NO | By calling me at my work phone number______________________ |
| YES | NO | By leaving messaged at my cell phone number |
| YES | NO | By calling me at my cell phone number______________________ |
| YES | NO | By leaving messages on my cell phone voicemail |
| YES | NO | By leaving messages on my cell phone by text |
| YES | NO | By e-mail(which may or may not be encrypted) e-mail address______________ |
| YES | NO | By leaving a message with any individual who answers my phone(s) |

**PLEASE NOTIFIY THE STAFF IF YOU WISH TO MAKE ANY CHANGES TO THESE DIRECTIVES.**
**ORINGINALS TO BE MAINTAINED IN PATIENT'S PERMANENT MEDICAL RECORD.**