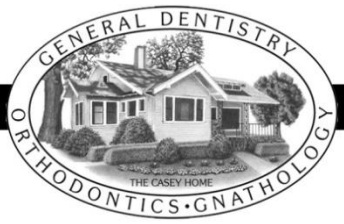

Health Insurance Portability & Accountability Act Consent Form (HIPAA)

Due to HIPAA, our office is required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office reception area for patients to review. Please sign this as your acknowledgement that this office is following HIPAA policy requirements.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our Notice of Privacy Practices and Dental Materials Fact Sheet before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

Please initial the following statements:

____ Protected information may be disclosed or used for treatment, payment, or healthcare operations.

____ The practice has a Notice of Privacy Practices and I have had the opportunity to review that notice.

____ The practice reserves the right to change the Notice of Privacy Policies.

____ The patient may revoke this consent in writing at any time and all future disclosures will then cease.

____ The practice may condition treatment based on the execution of this consent.

_____

In order to insure the accuracy of your protected health information, our office may update this form regularly.

I authorize Brian J. Hockel, DDS and his employees to release my dental information as necessary to coordinate or manage my dental care. (This includes insurance information, if applicable.)

In the event that a family member or caregiver attends my dental visit and is in the exam room at the time of my evaluation or treatment, I give Brian Hockel, DDS and his employees my permission to discuss freely, my condition, treatment, financial terms, or diagnosis with that person.

Home Phone: ( ) _____ May we leave a detailed message? YES / NO

Work Phone: ( ) _____ May we leave a detailed message? YES / NO

Cell Phone: ( ) _____ May we leave a detailed message? YES / NO

Email: _____ May we send a detailed message? YES / NO

List names of those we may discuss issues relating to diagnosis, treatment, and financial arrangements:

_____

List the address where billing statements & other correspondence may be sent:

_____

Date: _____ Printed name of patient: _____

Signature: _____ Relationship to patient: _____