Kacy Family Dentistry, PC
77 W. Square Lake Rd.
Troy, MI 48098
PH: (248) 879-2980
FX: (248) 879-2983

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains dental records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication with the many health care professionals who contribute to my care
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for providers and specialist to assess the quality and the competence of the dental care, provided, as well as the detection of any possible future issues

I understand that I have the right to review the notice prior to signing this consent. I understand that the terms of this Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Date: _____

Signature: _____

Print Patient Name: _____

Relationship to Patient: _____