Cosmetic, Full Mouth Reconstruction, TMJ & Sleep Apnea Dentistry

IRA D. KOEPPEL DDS

"Changing Lives... One Smile at a Time"

PATIENT HIPAA AWARENESS

I have reviewed the Notice of Privacy Practices as required by Section 164.520 of the Federal Health Insurance Portability and Accountability Act (HIPAA) prior to signing this consent.

In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I authorize the office of Ira D. Koeppel, DDS, PC of East Setauket:

1. To use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment and Healthcare Operations (TPO) according to the Notice of Privacy Practices.

2. To call me at home or other designated locations and leave a voice message or talk to me in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care including laboratory results among others.

3. To mail to my home or other designated locations any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that the office of Ira D. Koeppel DDS, PC of East Setauket restricts how it uses or discloses my PHI to carry out TPO.

By signing this, I am allowing the office of Ira D. Koeppel DDS, PC of East Setauket to use and disclose my PHI for TPO.

I understand that I have the right to revoke this authorization at any time in writing.

Signature: _____

Print Patient's Name: _____

Signature of Parent or Guardian: _____

Personal Representative's Name: _____

Relationship to Patient: _____

Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the Patient's chart

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