Joe R. Keneson, D.D.S.
James R. Landis, D.D.S.
1164 Hwy 327 E
Silsbee, TX 77656
409-385-3651

Notice of Privacy Practices Acknowledgement

PATIENT CONSENT FOR USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
under the Health and Insurance Portability & Accountability Act of 1996 (HIPAA)

Patient Name:_____ Date of Birth_____

I hereby give my consent for Joe R Keneson, D.D.S., and staff of the Joe R. Keneson, D.D.S. Dental Office to use and disclose protected dental health information about me to carry out treatment, payment and dental health care operations. The Notice of Privacy Practices provided by Joe R. Keneson, D.D.S. describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Joe R. Keneson, D.D.S. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office of Joe R. Keneson, D.D.S., at above address.

With this consent, Joe R. Keneson, D.D.S. and the staff of the Joe R. Keneson, D.D.S. Dental Office may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment for dental care operations, such as appointment reminders, insurance items, and any calls pertaining to my dental care, including test results, among other reasons. *We offer you the opportunity to list names of any other individuals that you may also want to have knowledge of your test results in your absence.*

_____I authorize Joe R. Keneson, D.D.S. and the Staff of his Dental office to offer ANY test results over the phone to the following persons: (This may include your spouse, parent, child or any person designated by you.) ***Only persons you list here will be told your test results and discuss you dental care.***

_____ ***Relationship to patient:***_____

_____ ***Relationship to patient:***_____

_____ ***Relationship to patient***_____

_____ ***I DO NOT*** wish for any of my test results or dental conditions, to be discussed with anyone but myself.

With this consent, Joe R. Keneson, D.D.S. and the staff of the Dental office may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and dental care operations, such as appointment reminders and patient statements.

By signing this form, I am consenting to allow Joe R. Keneson, D.D.S. and the staff to use and disclose my protected dental information to carry out treatment, payment and dental care options.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in relieance upon my consent. If I do not sign this consent, or later revoke it, Joe R. Keneson, D.D. S. and his staff may decline to provide treatment to me.

Signature of Patient/ Legal Guardian

_____ Date_____

Print Name of Legal Guardian *if applicable*:_____