MICHAEL S. SHRECK, D.M.D., P.C.

Periodontics & Implants

Patient HIPPA Awareness

With my permission, Dr. Michael Shreck may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Shreck's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Shreck reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Dr. Shreck may call my home or other designated locations and leave a message on a voice mail or in person in reference to any items that assist the practice in carrying out TPO. Such include appointment reminders, insurance items, laboratory results and any calls pertaining to my clinical care.

With my permission, the office of Dr. Shreck may e-mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Shreck restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Shreck to use and disclose my PHI for TPO.

I may revoke my consent in writing except that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

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