Schuster Family Orthodontics

**PATIENT HIPAA AWARENESS AGREEMENT**

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

A copy of the Notice of Privacy Practices was made available to me prior to signing this consent. The Practice 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 Privacy Officer.

With my permission, the office of Schuster Family Orthodontics may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my orthodontic care..

With my permission, the office of Schuster Family Orthodontics may mail to 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 The Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, though if it does so, is bound by this agreement.

By signing this form, I am allowing Schuster Family Orthodontics LLC to use and disclose my PHI for TPO.

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

I may make the following special request for confidential communications:

_____
_____
_____
_____

_____ _____/_____/_____
Signature of Patient or Legal Guardian Date

_____
Print Patient's name

_____ _____/_____/_____
Print Legal Guardian's name Date