Masha Kogan, DDS

HIPAA PRIVACY AUTHORIZATON FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act -- 45 CFR Parts 160 and 164)

I hereby authorize the Dental Center of Westport to use and/or disclose the Protected Health Information ("PHI") about me to carry out Treatment, Payment and healthcare Operations ("TPO").

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Dental Center of Westport reserves the right to revise its Notice of Privacy Practices at any time; such revised notice will be furnished upon a written request.

I hereby authorize the Dental Center of Westport to call my home or other designated phone numbers and leave a voice mail in reference to any items that assist the office in carrying out the "TPO", such as appointment reminders, insurance items and any other items pertaining to my clinical care, including laboratory results.

I hereby authorize the Dental Center of Westport to send mail to my home or other designated address any items that assist the office in carrying out the "TPO", such as appointment reminder cards and patient statements.

_____ _____

Patient/Guardian Name (Print) Signature

_____

Date

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