Keith M. Koga D.D.S.
98-211 Pali Momi St. Suite 725
Aiea, HI 96701
(808)484-0600

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected dental information is used and disclosed. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected dental information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected dental information may be disclosed or used for treatment or payment.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- This practice will verify the identity of anyone requesting protected dental information. Verification information will be the patient's birthdate.

May we phone, email, or send a text to you to confirm appointments: Yes No
May we leave a message on your answering machine at home or on your cell? Yes No
May we send the school or employer absentee excuses? Yes No
May we discuss your dental condition with any member of your family? Yes No
If YES, please name the members allowed and their relationship to you:

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Patient's Name (Print): ______________________________

Patient's Signature: ______________________________

Date: ____________________