Barden Family Dentistry
301 E. Main Street
P.O. Box 400
Osawatomie, KS 66064
(913) 755-3014

PATIENT HIPAA AWARENESS

Effective date: 2-16-2026

With my permission, Barden Family Dentistry may use and disclose protected information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Barden Family Dentistry 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. Barden Family Dentistry 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 Barden Family Dentistry may call my home, or other designated locations, and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, such as laboratory results, among others.

With my permission, the office of Barden Family Dentistry may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, and patient statements. This also includes texting appointment reminders.

With my permission, the office of Barden Family Dentistry may e-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 Barden Family Dentistry restricts 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 agreement, I am allowing Barden Family Dentistry to use and disclose my PHI for TPO.

The above agreement does not apply to 42 CFR Part 2 and may require your specific written consent for use or disclosure. Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

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

_____
Signature of Patient or Legal Guardian

_____
Date

_____
Print Name of Patient or Legal Guardian