Dr. Jennifer L. Kiening
205 Denali Pass, Suite A. Cedar Park, TX 78613

Health Insurance Portability and Accountability Act (HIPAA)

Child/Children's Names: _____

Parent/Guardian's Name: _____

Phone #: _____Work #_____Cell #_____

Address: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) is made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manners (check all that apply)

Home Telephone:

Ok to leave message with details ☐
Ok to speak to spouse/siblings ☐

Written Communications:

Ok to mail to my home ☐
Ok to fax to designated # ☐

Work Telephone:

Ok to leave message with details ☐
Leave message with call back ☐

I give Dr. Kiening permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations) this also indicated a "Good Faith Effort" was made on behalf of Dr. Kiening. By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for six years.

_____ _____

Signature Date