Scott L Kuhns DMD, PA

3727 SE Ocean Blvd. , Suite 208

Stuart,Florida 34996

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

HIPAA NOTICE OF PRIVACY PRACTICES FORM AVAILABLE UPON REQUEST

Signature below is on acknowledgement that you have been informed of the HIPAA Notice of Privacy Practices form:

Signature:_____**Date:**_____

Print Name:_____

Scott L. Kuhns D.M.D. PA.
3737 S.E. Ocean Blvd. Suite 208
Stuart, FL 34996
772-287-1400

Photo Release

In connection with the dental services that I am receiving from Scott L. Kuhns D.M.D. PA. and his dental staff, I hereby authorize Scott Kuhns and his respective agents to disclose any, all information concerning my dental condition and treatment including copies of applicable dental and medical records to:

1. any third party payer covering the services of the patient;
2. other health care professionals and institutions involved in the delivery of health care to the patient;
3. the proponent of any legally sufficient subpoena, or response to a court order;
4. employees and agents of the practice, to the degree necessary to facilitate the provisions of health care services and payment for such services
5. as otherwise required by law.
6. disclosed as part of an educational presentation.

I further consent that photographs or video may be taken of me or parts of my mouth, under the following conditions:

1. The photographs or video may be taken by my dentist, his employees and agents of the practice or a photographer.
2. the photographs or video shall be used for dental records, and if in the opinion of my dentist, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published by republished, either separately or in connection with each other in professional journals or medical books, or used or any purpose which he may deem proper in the interest of dental education, knowledge, or research; provided, however, that this is specifically understood that in any such publication or use, I shall not be identified by name, reasonable steps shall be taken to preserve my identity.
3. The aforementioned photographs or video may be modified or retouched in any way that my dentist, in his discretion, may consider desirable.
4. The aforementioned photographs or video may be be used for advertising purposes, whether it be print, television, interview, or other forms.

This consent is valid from the date executed until revoked in writing by the patient.

Signed:_____ Date_____
Witness:_____