Timothy J. Kitzmiller, D.D.S.

Consent for Release of Information
I understand that, under the Health Insurance Portability & Privacy Accountability Act of 1996 (HIPPA), that I have certain rights to privacy in regards to my protected health information. I authorize Timothy J. Kitzmiller, D.D.S. to release this information to: conduct normal healthcare operations, obtain payment from third-party payers, and plan my treatment and follow up with other healthcare providers.

Change of Insurance Carrier(s) and/ or Coverage
I understand that it is my responsibility to inform Timothy J. Kitzmiller, D.D.S. of any changes in my insurance carrier and/or coverage. Any charges that are acquired as a result of not informing Timothy J. Kitzmiller, D.D.S. of these changes are my financial responsibility and must be paid within 60 days of the date of service.

Receipt of Privacy Polices and Practices
I have received a copy of Timothy J. Kitzmiller's Privacy Polices and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing to restrict how my private information is disclosed to carry out treatment or for payment by a third-party payer.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Patient's Name Date of Birth

Legal Representative Information:

Name:_____ Relationship:_____

Address:_____
Street City State Zip

Phone #:_____