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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient giving consent:
Patient's Name______________________________ Date of Birth______________

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my PHI.

I understand that my doctor and his staff may use and disclose my PHI to help provide health care to me, to handling billing and payment, and to take care of other healthcare operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

My doctor has a detailed document call the "Notice of Privacy Practices". It contains more information about the policies and practices protecting my privacy. My doctor may update this notice. If I ask, my doctor or his staff will provide me with the most current notice and the current notice will always be posted at my doctor's office.

I authorize the release of information to the following individuals who may participate in my care following dental treatment:

Name:______________________________ Relationship to Me:____________________________

Name:______________________________ Relationship to Me:____________________________

I authorize information such as appointment confirmations and insurance information to be left on my home phone: Y______ N______

My signature below indicates that I have been given a current copy of my doctor's "Notice of Privacy Practices". I understand that I have the right to read and ask any questions regarding the "Notice" before signing this agreement.

Patient (or legally authorized individual) signature________________________Date__________
Relationship to patient _______________________________