ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices
Please Print

X_____ _____
Signature Date

CONSENT FOR USE AND DISCLOSURE OF DENTAL HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected dental health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected dental health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Contact Person. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my protected dental health information to carry out treatment, payment activates and health care operations.

X Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected dental health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date _____

Patient HIPPA Release Form

The Health Insurance Portability & Accountability Act (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential.

A copy of this policy is available to you at your request and on our website.

The Doctors and Staff of Hall, Clark, and VanOverloop may release information on my health to the following Individuals:

Name_____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship**_____

X Signature _____ Date _____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgments could not be obtained because:

☐ Individual refused to sign ☐ Communications barriers prohibited obtaining the acknowledgment

Staff:_____