DISABILITY DENTAL SERVICES

Patient Name_____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Explanation: All medical facilities, are required by Federal and State law to provide each of their patients with a copy of their Notice of Privacy Practices, under the Health Insurance Portability and Accountability Act (HIPAA). This act went into effect April 14, 2003. In addition, we are required by Federal and State law to obtain a signed Acknowledgment from each of our patients indicating they have received this Notice and Consent from our patients to use their health care information for "treatment, payment, and healthcare operations." This act was passed by Congress to protect patients' rights concerning the use of their health care information. In other words, under the new HIPAA regulations, we must take measures to make sure your health care information is not released to parties without your authorization, except for what is necessary to complete our treatment and payment activities. This act will not affect the services you will receive at this office. In fact, the changes that have been made will not even be noticed by most patients. However, as stated above, we must obtain your signature below before treatment can be provided, so that this office stays in compliance with Federal and State laws. Thank you for your cooperation.

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make
of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy policies, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation or by signing a *Revocation of Consent* form, provided by this office, and submitted to the office's 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.

SIGNATURE
By my signature below I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of your Notice of Privacy Practices and this Consent form. I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information as necessary to carry out their treatment, payment activities, and heath care operations.

Patient/Guardian Signature_____
Date_____

If this Consent is signed by a parent, guardian, or personal representative on behalf of the patient, complete the following:
Representative's Name: _____

Relationship to Patient:

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