BEARDEN FAMILY DENTISTRY

Acknowledgment: Receipt of Notice of Privacy Practices

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name _____ Effective Date _____

Patient Acknowledgment

Patient Name (Please Print) _____

Patient Signature _____ Effective Date _____

Personal Representative Acknowledgment

I am the personal representative of:

Patient Name (Please Print) _____

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name _____

Personal Representative Signature _____ Effective Date _____

Personal Representative (Please Print) _____

Relationship to Patient _____

BEARDEN FAMILY DENTISTRY

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient or Legal Representative Signature

_____ _____

Signature of patient or legal representative Date

_____

Printed name of legal representative

_____

Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

_____ _____

Signature of patient or legal representative Date