Burleson ENDODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy. The privacy practices described are currently in effect.

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent, we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

"You May Refuse to Sign This Acknowledgement"

I,_____have been informed of this office's Notice of Privacy Practices and acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. By signing this I give my permission to use and disclose my health information.

_____

Print Name

_____

Signature

_____

Date

I AUTHORIZE INFORMATION REGARDING MY DENTAL APPOINTMENT AND DENTAL HEALTH TO BE COMMUNICATED VIA:

- ☐ Cell Phone
- ☐ Text Message
- ☐ Home Phone
- ☐ Work phone
- ☐ Email
- ☐ All of the above

_____ I am aware that electronic communication (especially unencrypted email) can be subject third-party intervention. I understand that any confidential health information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

_____ I do not give consent to electronic communication.

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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_____

Witness Signature