

# University Oaks Dental

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

### You May refuse to Sign This Acknowledgement

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

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Please Print Name

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Signature

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Date

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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# University Oaks Dental

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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### Section A: Patient Giving Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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### Section B: To the Patient – Please Read the Following Statements Carefully

**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 the Consent. We encourage you to read it carefully and completely before signing this Consent.

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. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

**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 the Contact Person listed above. 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 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 health information to carry out treatment, payment activities and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The Individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

### I wish to be contacted in the following manner (check all that apply):

<input type="checkbox"/> Home Telephone _____	<input type="checkbox"/> Written Communication
<input type="checkbox"/> O.K. to leave message with detailed information	<input type="checkbox"/> O.K. to mail to my home address
<input type="checkbox"/> Leave message with callback number only	<input type="checkbox"/> O.K. to mail to work/office address
<input type="checkbox"/> Work Telephone _____	<input type="checkbox"/> O.K. to fax to this number _____
<input type="checkbox"/> O.K. to leave message with detailed information	<input type="checkbox"/> O.K. to e-mail at home or work
<input type="checkbox"/> Leave message with call back number only	
<input type="checkbox"/> Leave message with secretary or other employee	
<input type="checkbox"/> Other _____	

### Approval for Personal Representative(s) to Have Access to Your Records

If you wish to authorize a personal representative(s) to have complete access to your records, please complete the following:

Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for (PHI) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual.

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