ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement that you have read our Notice of Privacy Practices in its entirety, understand your rights and to document our good faith effort to obtain that acknowledgement.

****The law doesn't require you to sign this Acknowledgment****
****Signing doesn't mean that you have agreed to any special uses or disclosures of your PHI****
****Refusing to sign doesn't prevent a provider/plan from using/disclosing your PHI as HIPAA permits****
****We are required to document your refusal****

I,____have read a copy of the Smiles of Aurora Notice of Privacy Practices, understand my rights and the ways my PHI may and may not be used and/or disclosed.

Print Patient Name: ____

Signature of Patient of Guardian: ____

Date:_______________________________

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective August 2013

Name: ____

Date of Birth:________________________

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 this 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.

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 if you revoke this Consent.

SIGNATURES

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 health care operations.

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: ____

EMAILING DIGITAL X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email digital x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

I understand that digital x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

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: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

Personal Health Information Disclosure Authorization
for Smiles of Aurora
to Release My PHI

Purpose: This form is used to obtain authorization to release information regarding you, covered under the Privacy Act to people other than yourself.

I, ____, do hereby grant permission for Smiles of Aurora, to disclose my personal health information to the following personal representatives(s): Please designate spouse, sibling, parent, child, friend, etc.

____ ________________________________
(print name) (relationship)

____ ________________________________
(print name) (relationship)

____ ________________________________
(print name) (relationship)

Information to be disclosed (please check):

- ❑ Appointment dates and times
- ❑ Treatment plans and referrals
- ❑ Financial and billing information
- ❑ Any other pertinent dental health information related to treatment at this office.
- ❑ None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Smiles of Aurora.

____ ___________________________________
(Print Patient Name) (Patient's Date of Birth)

____ ___________________________________
(Patient Signature) (Date)