Family Dental Care

HIPPA CONSENT

Patient Consent Form

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. You may have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy within 2 weeks of our change.

You have the right to request that we restrict how protected health information about you is used or disclosed for the treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

_____	_____	_____
Please Print Name	**Signature**	**Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICES OF PRIVACY PRATICES

PERMISSION TO USE INFORMATION

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMTN****

I, _____, have received a copy of this office's Notice of Privacy Practices. I give this office, Family Dental Care, permission to use my health information to treat me as outlines in the HIPPA notice.

_____	_____	_____
Please Print Name	**Signature**	**Date**

****FOR OFFICE USE****

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

◯ Individual refused to sign ◯ Communication barriers prohibited obtaining the acknowledgement

◯ An emergency situation prevented us from obtaining acknowledgement ◯ Other

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