Patient Acknowledgement and Disclosure Form

This form is required by the Health Insurance Portability and Accountability Act of 1996 in compliance with the privacy regulation effective for this office on October 1, 2007, only if our office wishes to use or disclose your protected health information for any other purpose not clearly spelled out in our office Privacy Policy Notice.

To use or disclose your protected health information in such cases, our office must receive prior written authorization from you. Our office will condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

The purpose for which our office is requesting your authorization is to diagnose and complete treatment. The information to be disclosed would include your protected health information. The information may be disclosed to, but not limited to, laboratories, hospitals, insurance companies, medical and dental referrals, and other health care professionals. This form also authorizes the use of photography as a diagnostic tool.

By agreeing to this authorization, you understand that the potential for information disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer protected by the privacy regulation of HIPAA. You also understand that you are entitled to receive a copy of this authorization form.

I, _____, acknowledge that I have viewed and am aware of the Privacy Policy Notice for the office of Smith & Co. Dental Practitioners and give my authorization to Dr. Smith for the purpose stated above. I understand that I can revoke this authorization at any point in the future by submitting written notice to Dr. Smith.

Patient Signature: _____

Date:_____

Patient Communication and Record of Disclosures Form

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of the protected health information.

The individual is also provided the right to request confidential communications or that a communication of protected health information 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)

- o Home Telephone
  - o Leave message with detailed information
  - o Leave message with call back number only
- o Work Telephone
  - o Leave message with detailed information
  - o Leave message with call back number only
- o Written Communication
  - o Send to home address
  - o Send to work address
  - o Fax to this number _____

- Other ____ __________________________