# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

## DENTAL CARE TODAY, PC

## E. DALE BEHNER, D.D.S.

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

**Name:** _____

Address: _____ Telephone _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS.

**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.

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

**CONTACT OFFICER: LYNN BEHNER, BUSINESS ADMINISTRATOR** **TELEPHONE: 317-842-2337** **FAX: 317-842-1640**

ADDRESS: 9744 LANTERN ROAD, FISHERS, IN 46038

**PATIENT INITIALS/SIGNATURE**

Patient's Initials_____ I have received a copy of this office's privacy practices and have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices.

Patient's Initials_____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 heath care operations.

Patient's 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.**

### RESTRICTIONS FOR RELEASE OF PROTECTED HEALTH INFORMATION

I am exercising my right to restrict the disclosures made on my protected health information. I have listed below specific instructions for this office to follow regarding the disclosure of my protected health information. I understand these restrictions will remain in effect until I inform this office in writing otherwise.

Restriction Intructions:_____
_____
_____
_____
_____

Patient's Name:_____Date_____

Authorized Signature_____

Relationship of Authorized Person, if other than Patient:_____

**REVOCATION OF CONSENT**

**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 if you revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Patient's Name:_____Date_____

Authorized Signature_____

Relationship of Authorized Person, if other than
Patient:_____

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***Office Use Only***

**Please keep a copy of this form in the patient's chart**

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

Patient Name:_____Date:_____

- ☐ Individual refused to sign Consent Form
- ☐ Privacy Practices notification was given to patient
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Patient/Representative chose to not sign the consent form until further review
- ☐ Other (Please Specify

_____
_____

Office Signature _____ Date _____