Croasdaile
DENTAL ARTS
Your Smile. Our Passion.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your ***NOTICE OF PRIVACY PRACTICES*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***NOTICE OF PRIVACY PRACTICES*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***NOTICE OF PRIVACY PRACTICES.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____
Relationship to Patient: _____
Signature: _____
Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: ____ Reason: _____

Revised 05/27/17

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ **Date of Birth** _____

Croasdaile Dental Arts is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you Approve to receive information	**Description of information to be released.** Check each that can be given to person/ entity on the left in the same section.
____ VOICE MAIL/ANSWERING MACHINE	____ Results of lab tests/x-rays ____ Appointments, follow-up calls or insurance
____ EMAIL Email address_____ ____TEXT APPTS to # _____	____ Financial ____ Correspondences: Recall cards, newsletters, announcements, etc. ____ Appointments, follow-up calls or insurance.
____ SPOUSE (provide full name) _____	____ Financial ____ Appointments, follow-up calls or insurance.
____ PARENT (provide names) _____	____ Financial ____ Appointments, follow-up calls or insurance.
____ OTHER (provide names) _____	____ Financial ____ Appointments, follow-up calls or, insurance.

Patient Information

I understand that I have the right to revoke this information at anytime and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse or sign this authorization and that my treatment will be conditioned on signing. **This authorization shall be in effect until revoked by patient.**

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority: _____

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