Treasure Coast Dental

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (HIPAA)

I, ______________________, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for verifying my diagnosis and procedure billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that if I wish to obtain a copy of the notice of information practices that provides a more complete description of information uses and disclosures, one will be made available for me. I understand that I have the right to review the notice prior to signing the consent. I understand that this practice reserves the right to change their privacy practices, and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request a restriction of how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this practice is not required to agree to the restrictions requested. I understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand and authorize, that at times it will be necessary for this office to call my home or place of business and leave messages on an answering machine, voice mail or e-mail.

For purposes of proper medical/dental treatment, this office will give personal health information, including medical history and all test, x-rays and lab results, directly to the patients other healthcare professionals. Transfer of this information is intended solely for the purpose of appropriate care for me as the patient.

I wish to have the following restrictions to the use or disclosure of my health information:

I have read and understand this Consent Agreement

Signature____ Date_________________________
Patient, parent or legal guardian

Please Print Name____

Witness____ Date_________________________