STEVEN J. AUSTIN, D.D.S.

PRIVACY PRACTICES
Patient Acknowledgement of Receipt
Of PRIVACY PRACTICES

****you may refuse to sign****

I, _____, have received a copy of the Notice of Privacy Practices. I understand that the purpose of this form is to document that this office has made an effort in helping me be aware of the required privacy practices under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

_____
Print Name

_____
Signature

_____
Date

Office Use Only

An attempt was made to obtain written acknowledgement of receipt of the Notice of Privacy Practices but not obtained because:

- ☐ Prevented by an emergency situation
- ☐ Communication (language) barriers
- ☐ Refusal to sign
- ☐ Other (Please Specify)

_____

_____

_____

PATIENT CONSENT
FOR
USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care.

By signing this consent form you will have acknowledged that you have read our Notice of Privacy Practices.

You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, _____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF 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 any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature: _____ Date: _____