ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

Patients Name: _____ DOB: _____

Primary Responsible Party: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

"PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY"

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: Martin Kids Dental Health Team & Martin Orthodontics of Chiefland.

Right to revoke: You will have the right to revoke this consent and any time by giving us written notice of our revocation. 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, the above signed party, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices I understand that, by signing this consent form, I am giving my consent for your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

I have received a copy of the Notice of Privacy Practices.

_____ _____

Date Primary Responsible Party

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

Office use only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining acknowledgement
- ☐ Other:_____