HIPAA ACKNOWLEDGEMENT

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement. A copy is provided in this packet.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Printed) _____

Signature _____ Date _____

TELEPHONE AND MAIL NOTIFICATION CONSENT

Due to our concern for your confidentiality, we are asking you sign this release which would allow us to contact you, the patient, about your upcoming appointments and/or dental treatment.

YES, I GIVE MY PERMISSION (PLEASE CHECK ALL THAT APPLY)

☐ AT HOME / CELL ☐ EMAIL

☐ AT WORK ☐ ANSWERING MACHINE / VOICEMAIL

☐ NO, PLEASE DO NOT CONTACT ME IN ANY OF THE ABOVE WAYS OF COMMUNICATION

2800 Niles Road, Saint Joseph, MI 49085

Tel: 269-429-2511 | Fax: 269-429-5130 | info@smilesonniles.com | www.smilesonniles.com

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

Name (Printed) _____ Relationship _____

Name (Printed) _____ Relationship _____

Name (Printed) _____ Relationship _____

FOR OFFICE USE ONLY

We attempt to obtain written ackowledgment of receipt of our Notice of Policy Practices, but acknowledgment could not be obtained because:

Individal refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (*Please Specify*)

_____

_____

_____

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