

Family Dentistry of Royal Oak

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

NAME: _____

Address: _____
(Street) (City) (Zip)

Telephone: _____ email: _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent and Acknowledgement: By signing this form, you acknowledge that you have received a copy of this office's Notice of Privacy Practices and you 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 Acknowledge and Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure 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 acknowledgement Consent. We encourage you to read it carefully and completely before signing this Acknowledgement and 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:

CONTACT OFFICER: Dr. Suchi Chalasani 2711 West Webster Road, Royal Oak, MI 48073
Telephone: 248-399-8100 FAX: 248-399-8286
E-mail: dentistsuchi@yahoo.com

Right to Revoke: You will have the right to revoke this Acknowledgement and Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Acknowledgement and Consent will not affect any action we took in reliance on this Acknowledgement and Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Acknowledgement and Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Acknowledgement and Consent form and the Family Dentistry of Royal Oak Notice of Privacy Practices. I understand that, by signing this form, I am acknowledging receiving a copy of the Notice of Privacy Practices and am also giving my consent for Family Dentistry of Royal Oak to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Acknowledgement and Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

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

REVOCAION 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 revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

FOR OFFICE USE ONLY	
We attempted to obtain written ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRATICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION, but acknowledgement and consent could not be obtained because:	
<input type="checkbox"/>	Individual refused to sign
<input type="checkbox"/>	Communication barriers prohibited obtaining the acknowledgement and consent
<input type="checkbox"/>	An emergency situation prohibited us from obtaining the acknowledgement and consent
<input type="checkbox"/>	Other (Please specify)