Patient HIPPA Acknowledgement & Consent

Restorative Dental

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Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice:

_____(Patient/Representative Initials) I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members:

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUALS WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL/DENTAL CONDITION? IF YES, WHOM? I give **permission** for my Protected Health **Information to** be **disclosed** for **purposes** of **communicating results, findings,** and care **decisions to** the family **members and** other **listed below:**

Name	Relationship	Contact Phone Number

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare:

I agree the Provider or an agent of the Provider or an independent healthcare provider's office may contact me for the purposes of scheduling necessary or recommended consults, exams, testing, treatment, and/or follow-up visits recommended by the Provider.

Consent for Photographing or Other Recording for Security and/or Health care Operations:

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's health care operations purposes (ie: quality improvement activities). I understand that the practice retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

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Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Services have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical/dental care. NOTE: You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Release of Information:

I hereby permit the practice and the healthcare professionals involved in my care to release healthcare information for the purposes of treatment, payment, or healthcare operations.

Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment f a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory or testing reports, operative reports, treatment progress notes, administrative notes, consultations, drug reports, and/or communications from other healthcare providers.

I certify that I have read and fully understand the above statements from all pages, and fully and voluntarily consent to its contents.

Patient/Representative Signature	Relationship to Patient (Self, parent, legal guardian/representative. etc)	Date