HEALTHY SMILES FAMILY DENTISTRY HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

Patient Last Name	Patient First Name	MI	Date of Birth

Notice of Privacy Practices

____**(Patient/Representative Initials)** I acknowledge that I have received the Notice of Privacy Practice **(NPP)** 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 Privacy Officer designated on the notice 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 NPP.

Disclosures to Friends and or Family Members

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

	Name	Relationship	Contact Phone Number
1			
2			
3			

Patient/Representative may revoke or modify this specific authorization in writing to the practice.

Communications about My Healthcare: I agree the Provider or agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating doctor.

Consent for Photographing for Security and or Health Care Operations: I consent to photographs for patient care, security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities.) I understand that the practice retains the ownership rights to the images.

I will be allowed to request access to, or copies of, the images when technologically feasible unless otherwise prohibited by law. I understand that these images will be securely stored and protected. Images 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.

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. These instructions may include, but not be 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 dental care. NOTE: You may opt out of these communications at any time.

Release of Information: I hereby permit the practice to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior service may be made available to other providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf 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.

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

Patient/Representative Signature	Relationship to patient(ie: self, parent, legal guardian etc)	Date