Dentistry for Children

FOR OFFICE USE

Patient ID#: _____

Acknowledgement of Receipt of HIPAA Privacy Practices

Please read the following statement carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your (your child's) protection health information to carry out treatment, payment activities, and healthcare operations. You also acknowledge that you have been provided with access to a copy of the company's Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. This notice provides a description of how your (your child's) information is used to ensure treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time from the dental office, our website, or by contacting the Privacy Officer:

Title: Privacy Officer
Address: 300 Willowbrook Lane, Suite 330, West Chester, PA 19382

Changes to Privacy Practices: 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 (your child's) protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed below. Please understand the 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 (your child) if you revoke this consent.

Acknowledgement

I 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 the use and disclosure of my (my child's) protected health information to carry out treatment, payment activities and health care operations, as described in the Notice of Privacy Practices.

Patient's Name: _____ DOB (MM/DD/YY): _____

Signatory's Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices; however, acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____