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Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Please sign this form below to acknowledge that you have either received or reviewed a copy of our Notice of Privacy Practices and to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that I have either received or reviewed a copy of the Notice of Privacy Practices.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature

Patient Name (please print)

Date

I am also signing for my minor children: _____

(please print names)

(please print names)

Release of Information

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship