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HIPAA Acknowledgement and Patient Consent Form

Patient Name:_____

Date of Birth:_____

_____(Patient Initials) **Notice of Privacy Practices.** Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. By your initials you acknowledge that you have received GVDC Notice of Privacy Practices.

_____(Patient Initials) **Release of Information.** The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By your initials, you consent to our use and disclosure of your protected healthcare information for treatment, payment, or dental/healthcare operations. My consent to disclosure of records shall be effective until I revoke it in writing.

Disclosures to Friends and/or Family Members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM GREEN VALLEY DENTAL CARE MAY DISCUSS YOUR DENTAL/MEDICAL CONDITION? IF YES, WHOM?
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decision to the family members and other listed below:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

May we phone, email, or send a text message to you to confirm appointments? YES NO

Preferred method of contact: Home Phone_____ Cell Phone_____ e-mail _____ Text Message_____

May we leave a message on your answering machine at home or on your cell phone? YES NO

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____