Acknowledgement of Receipt of HIPAA Notice & Privacy Practices

I, _____, hereby acknowledge that I have received and reviewed a copy of East Indy Dental Care's HIPAA Notice of Privacy Practices.

I understand that East Indy Dental Care's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of East Indy Dental Care's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about East Indy Dental Care's HIPAA Notice of Privacy Practices, I may contact the privacy official at East Indy Dental Care.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that East Indy Dental Care will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should have concerns regarding East Indy Dental Care's privacy policies and procedures.

_____ *Signature of Patient*
_____ / _____ / _____ *Date*

_____ *Signature of Responsible Party*
_____ / _____ / _____ *Date*

_____ *Printed Name of Responsible Party*

Relationship _____

HIPAA Information Communication Release

The HIPAA privacy law dictates that we are only authorized to communicate with patients themselves, guardians, insurance providers and patients' physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking "DO NOT RELEASE INFORMATION" box below.

I give the following named person(s) authorization to take messages or speak with the office of East Indy Dental Care on my behalf, regarding (please check all items authorized). Please note that information will be shared with these parties on a strictly "as needed" basis.

NAME OF AUTHORIZED PERSON(S): _____
Relationship: _____ Phone Number: _____
Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N
Other: _____

NAME OF AUTHORIZED PERSON(S): _____
Relationship: _____ Phone Number: _____
Able to Discuss (circle all that apply):

Appointments: Y | N Financial: Y | N Dental Treatment: Y | N Insurance: Y | N Medical History: Y | N
Other: _____

DO NOT RELEASE INFORMATION TO ANYONE: _____ (Initial)

I understand that my express written consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contact listed above.

Patient's Name: _____ Date: _____

Signature of Patient or Authorized Representative:

_____