HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the disclosure of Protected health information
For Treatment, Payment, or Healthcare Operations (164.508(a))

I,_____(patients name)understand that as part of my healthcare, this facility **Originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as;**

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that the service billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy of the notice of privacy practices that provides a more complete description of information uses and disclosures.
I understand that as part of my care and treatment it may be necessary to provide my processed health information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my protected health information as specified below for the purpose and to the parties designated by me.

Privacy Rule of Patient Consent

Consent to the use and disclosure of protected health information for treatment, payment, or healthcare operations (164.506(a))

I understand that:

- I have the right to review this facility's notice of information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my protected health information may be uses or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time , except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share protected health information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary protected health information for each transaction.

Signature of patient or legal representative witness_____
Printed name of patient or legal representative witness_____

X

Date:_____

HIPAA Privacy Rule Receipt of Notice of Privacy
Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practice Notice (164.520 (a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;

- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy any revised notice to the address I've provided if requested.

Signature of Patient or Legal Representative (Guardian)
X_____

Printed Name of Patient or Legal Representative (Guardian)
X_____

Witness_____
Dr. Cooper's or HIPAA Representative

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____ Individual refused to sign
____Communication barrier prohibited obtaining acknowledgement
____An emergency situation prevented us from obtaining acknowledgement
____Others (please specify)

_____ _____
HIPAA Officer Date

I, _____, AKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE DENTAL MATERIALS FACK SHEET DATED OCTOBER, 2009

THIS IS TO COMPLY WITH SENATE BILL 134 THAT BECAME EFFECTIVE JANUARY 1, 2002.

_____ _____

PATIENT SIGNATURE DATE