Goodheart Dental

Print Patient Name: _____Date of Birth: _____

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HIPPA - Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

I have reviewed/received a copy of this office's Notice of Privacy Practices.

Signature _____Date_____

Authorization for Use or Disclosure of Patient Information

I authorize the use and disclosure of my patient information as described below. I understand that information disclosed may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

- Any and All of my information
- Other-please specify _____

I authorize the following person (s) to receive this information:

_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by Goodheart Dental.

Signature _____ Date: _____

If Patient's Representative:

Print Name_____Relationship to Patient_____

Signature: _____

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- Other _____