NORTHERN FAMILY
DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

X_____
(Please Sign Name)

_____
(Date)

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
- ☐ Communication barriers prohibited obtaining the knowledge
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

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Consent For Use And Disclosure of Health Information

Section A: Patient Giving Consent

Name _____ Phone_____ Email _____

Address _____ SSN _____ /____ /_____

Section B: To the Patient - Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you read it carefully before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact person Karrie T. Williams, DDS
100 Sherwood Dr
PO Box 920
Roscommon, MI 48653

Phone (989)275-1919
Fax (989)275-1619

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the consent person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and then we may decline to treat or to continue treating you if you revoke this consent.

Signature:

I, _____ have had full opportunity to read and consider the contents of this consent form for your Notice of Privacy Practices, I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature X_____ Date ____/____/_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____