



# CASCADE DENTAL CARE

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

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## AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. Please indicate below your choice. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

- You May Disclose My Information to The Following       Do Not Disclose My Information to Anyone but Me

1. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_