Smiles for Life Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices

TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 is posted at the front desk and a copy can be made available to you by request. We encourage you to read it carefully and completely 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 new copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Becky McIntyre (Office Manager) **Telephone:** 540-828-2312 **Fax:** 540-828-2857
Email: smiles@smilesforlifeonline.com **Address:** 115 Oakwood Drive, Bridgewater VA 22812

This acknowledgement page will be retained in the patient's record.

I request that the following have access to my Personal Health Information:

Name _____ Relationship_____

I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Relationship_____

I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Relationship_____

I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

I have had full opportunity to read and consider the contents of this Consent form and the 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.

Patient's Name_____

Patient's Signature _____ Date _____

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

Personal Representative's Name _____ Relationship to Patient _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact 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 that we may decline to treat you or to continue treating you if you revoke this Consent.

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 ☐ An emergency situation prevented us from obtaining acknowledgment ☐Other _____