HIPAA Consent Form for Patients

GoodDay Dental, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES AND CONSENT FOR DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATIONS

ACKNOWLEDGEMENT OF CONSENT

By signing below, I hereby acknowledge that I have been provided with access to a posted copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities, and healthcare operations of the office as described in the Notice.

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Signature of the Patient or Personal Representative

_____

Print Name of Patient or Representative (including description of legal authority)

_____

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 refuses to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

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