BARDMOOR FAMILY DENTAL

Patient HIPPA Consent / Acknowledgment Form

Bardmoor Family Dental must obtain your written consent before it can disclose information about you for payment purposes. You must also sign a written consent form to share information for treatment purposes or health care operations.

Under the following circumstances Bardmoor Family Dental must disclose information:

- To provide treatment and maintain a dental record;
- Pursuant to an agreement with a business associates (e.g. Clinical laboratories, pharmacy, records storage services, billing services);
- For research, audit, or evaluations (e.g. State licensing review, accreditation, program data reporting as required by the State and/or Federal government);
- To medical personnel in a medical emergency;
- To appropriate authorities to report suspected abuse or neglect;
- To report certain infectious illnesses required by state law;

Before Bardmoor Family Dental can use or disclose any information about your health in a manner not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: should you choose not to sign the Patient Consent/Acknowledgment Form you may chose to refuse treatment.)

THIS FORM IS ALSO USED TO OBTAIN CONSENT / ACKNOWLEGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PARCTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGMENT.

I HAVE REVIEWED, UNDERSTOOD AND AGREED TO THE CONSENT OF BARDMOOR FAMILY DENTAL NOTICE OF PRIVACY PRACTICES.

Patient Signature: _____ Date: _____

Patient Name Printed: _____

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

Personal Representative's Name:_____

Relationship to patient: _____

PLEASE SPECIFY THE EXACT REASON WHY THE PATIENT CHOSE NOT TO SIGN THIS CONSENT / ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES.

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