ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/HIPAA

Joel F. Brodsky DDS Inc. / Brodsky Orthodontics

PART 1 - CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient's Name _____

Responsible Party's Name _____

Section B: To the adult patient, parent or guardian - Please read the following statements carefully.
Purpose of Consent: By signing below in Section C, you will consent to out use and disclosure of this patient protected health information to carry out treatment, payment activities and healthcare operations.

"You may refuse to sign this Acknowledgement." But should you choose not to sign our office may decline to treat this patient.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide to sign this consent. In the course of providing service, we create, receive and store health information that identifies this patient. It is often necessary to use and disclose this health information in order to treat patient, to obtain payment for our services, and to conduct healthcare operations involving our office. Our written Notice of Privacy Practices is available upon request.

We encourage you to read this Consent carefully and completely before signing it.

Section C: I have been given the opportunity to read and consider the contents of this Consent release that is included with my contract. I understand that, by signing this Consent, I am giving my consent to this office to use and disclosure of patient protected healthcare information to carry out treatment, payment activities and healthcare operations.

You can obtain a second copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by coming into our office in person. Office Address: Brodsky Orthodontics – 5920 Del Amo Blvd, Lakewood, CA 90713

RESPONSIBLE PARTY: I am giving consent for the patient above. ⇨ _____ _____
Signature of the Responsible Party Date

Section D: Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to our office at the above address. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation and that we may decline to continue treating the patient in your in your revoke of this Consent.

Revocation of Consent: (SAMPLE LETTER) I revoke my Consent for use and disclosure of my protected health information for treatment, payment activities and healthcare operations. I understand that revocation of my Consent will not affect any actions you took in reliance on my Consent before you received this written Notice Revocation. I also understand that you may decline to treat or to continue to treat patient after I have revoked my Consent.

I have received a copy of the Dr. Brodsky's Notice of Privacy Practices and have had full opportunity to read and consider the contents of the Consent form. I understand that by signing this Consent Form, I am giving my consent to use and discloser of patient protected healthcare information to carry out treatment, payment activities and healthcare operations.

PART 2 - HEALTH AND FINANCIAL INFORMATION DISCLOSURE CONSENT PLEASE REVIEW CAREFULLY.

Section E: You may wish to disclose this patient's health information to a family member or friends to the extent necessary to help with healthcare or payment information for this patient. Only the RESPONSIBLE PARTY has this right to agree that health and financial information can be disclosed to others.

I, the Responsible Party agree to disclose the patient's health and financial information to any of the following individuals:

1. _____
2. _____