



**Patient Acknowledgement and Consent Form**

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

**Patient Acknowledgement**

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to patient

**Patient Consent**

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures for, \_\_\_\_\_ which you deem are necessary in connection  
(Please Print Patient Name)  
with treatment. I understand that such disclosures may not be of the type listed above.

\_\_\_\_\_  
(Please print your name)

\_\_\_\_\_  
Relationship to patient

I also give consent for treatment to be discussed with the following individuals: (e.g., aunt, uncle, adult child, caregiver)

\_\_\_\_\_  
(Please print names)

\_\_\_\_\_  
Date

For Office Use Only	
Patient (parent/guardian) refused to sign. The following circumstances prohibited the patient from signing the Acknowledgement:	
_____	
An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.	
_____	_____
Office Personnel (signature)	Office Personnel (print name)
Date: _____	