

Rockside Family Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices & Consent for Use and Disclosure of Health Information

I, _____, agree to the following as marked below:

- I have received a copy of this office's Notice of Privacy Practices and give consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as stated on the back of this form.
- I have received a copy of this office's Notice of Privacy Practices but do not give consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as stated on the back of this form.

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 acknowledgement
- Other (Please Specify)

Patient Acknowledging/Consenting

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

Consent for Use and Disclosure of Health Information

Please read the following statements carefully

Purpose of Consent: By marking the appropriate box on the front of this form, and by signing at the bottom of this page, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 accompanies this Consent. We encourage you to read it carefully and completely before signing below.

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 copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Sonya Pifer at: Phone: 216-524-8481 Fax: 216-520-2868 or
E-mail: RocksideDental@aol.com or mail at:
6132 West Creek Road - Independence, OH 44131

Right to Revoke: You will 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. You may also refuse to sign this acknowledgment/consent form.

I have had full opportunity to read and consider the contents of this acknowledgment/consent form and your Notice of Privacy Practices. I understand that, by signing this form, I agree to the conditions denoted by the box that I have checked on the top of the front of this form.

Signature: _____ Date: _____

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

Personal Representative's Name: _____
Relationship to patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.