Rockside Family Dental Care

Acknowledgement of Receipt of Notice of Privacy Practices and
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 and **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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) _____

Patient Acknowledging / Consenting

Name: _____

Address: _____

Telephone: _____ Email: _____

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 or not 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 us via:

Phone: 216-524-8481
Fax: 216-520-2868
Email: info@rocksidedental.com
Mail: 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. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. You may also refuse to sign this acknowledgement/consent form. We may decline to treat you or to continue treating you if you refuse/revoke this consent.

I have had full opportunity to read and consider the contents of this acknowledgement/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 in the top section of the reverse side 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