HIPAA Privacy Rule Receipt of Notice of Privacy Practices

Written Acknowledgement Form

Brighton Periodontal & Implant Dental Group

Brighton Specialty Dental Group

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I,_____, (Patient's Name) understand that as part of my health care, Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group originate and maintain health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group's Notice of Privacy Practices prior to signing this acknowledgement;
- Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group reserve the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ……..…….....
Printed Name of Individual or Legal Representative Witness…….....
Date: ……

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____
_____
_____

_____ _____

Ms. Daisy Gagui
Privacy Official

Date

HIPAA Privacy Rule of Patient Authorization Agreement

Brighton Periodontal & Implant Dental Group

Brighton Specialty Dental Group

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (Patient's Name) understand that as part of my healthcare, , Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group originate and maintain health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group, reserve the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group are not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Brighton Periodontal & Implant Dental Group and Brighton Specialty Dental Group have already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness ……..……..
Printed Name of Patient or Legal Representative Witness ……
Date: ……..