DENTAL CARE ASSOCIATES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____
Please print your name here

____
Signature

____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

____

____

____

____ _________________

Employee Signature Date

DENTAL CARE ASSOCIATES
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: ____

Patient's Date of Birth: ______________________________ Patient's SSN: ______________________

Notice to Patient:
By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, ____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

____

Patient's Signature or Signature of Patient's Representative Date

____

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Kari Bonnevie

Practice Address: Dental Care Associates 2145 Lancelot Drive Wheatfield, NY 14304
Phone: 716-297-1644 Fax: 716-297-9855
E-Mail: office@dentalcareassociates.com

DENTAL CARE ASSOCIATES E-MAIL RELEASE FORM

Date:

I, ___________________________________ wish to communicate via e-mail with Dental Care Associates on matters related to my health and/or my medical treatment. I understand that any confidential health information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.

I also understand that is not the policy of the practice to encrypt any confidential health information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge the risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name: ____
(Print Patient's Name or Name of Patient's Representative)

Signature: ____
(Signature of Patient or Patient's Representative)

Witnessed By: ____
(Print Name)

Signature: ____
(Signature of Witness)

HIPAA E-Mail Release Form
Before sending any non-encrypted e-mail communications (including attachments) containing Protected Health Information to any recipient, ensure that this Form has been signed and is on file.
Provide a copy to the Patient.
Form 12