ENDODONTIC SERVICES

HIPAA OMNIBUS RULE PATIENT ACKNOWLEDGMENT FORMAT
ENDODONTIC SERVICES, INC.

PURPOSE: This form is to obtain an individual's permission for (a) our use of the individual's patient health care records to carry out treatment, payment activities, and health care operations. This consent is a condition of your treatment by us. If you choose not to sign this consent, we may decline to treat you. 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 uses and disclosure of your protected health information (PHI) and of other important matters about your protected health information.

In signing this HIPAA patient acknowledgment and consent form, you acknowledge and authorize that this office may recommend products or services to promote your overall health. This office may or may not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

How do you want to be acknowledged when being summoned from the reception area (please check one):

_____By First Name Only _____By Proper Sir Name (Mr. Mrs. Ms. With Last Name _____Other

Please list any other parties that can have access to your health information, patient records, and all other (PHI) protected health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OUR NOTICE OF PRIVACY PRACTICES ARE INCLUDED IN THIS CLIPBOARD, DISPLAYED AT THE FRONT DESK, AND ARE AVAILABLE FOR REVIEW ON OUR WEBSITE: WWW.ENDODONTICSERVICESINC.COM

OUR DISCLOSURE OF DENTAL INFORMATION/OTHER CONSENT:

I, (print your name) _____have been informed of this office's Notice of Privacy Practices. I understand by signing this form, I am confirming my written permission for the disclosure of my protected health information. (PHI)

Signature: _____ Date: _____

Parent/Legal Guardian (if minor):

_____ Date: _____