MARQUEE DENTAL PARTNERS

Acknowledgment of Receipt of Notice of Privacy Practices & Release of Information

I, _____ (Patient Name), understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ☐ Treatment (including direct or indirect treatment to other healthcare providers involved in my treatment). _____(Initial)
- ☐ Obtaining payment from third party payers (my insurance company). _____(Initial)
- ☐ I give permission for the practice to discuss my treatment and/or financial information with:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

I have received, read, and understood the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **[NAME OF ENTITY]** ("Practice") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time for a current copy of the *Notice of Privacy Practices* document. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and payment on health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Do we have your permission to:

Leave a message on your answering machine/voice mail?	☐ Yes ☐ No
Confirm appointments by leaving messages or speaking with family?	☐ Yes ☐ No
Leave pre-medication reminders (if applicable)?	☐ Yes ☐ No
Send Text Messages for reminders & practice information?	☐ Yes ☐ No
Send Email Messages for reminders & practice information?	☐ Yes ☐ No

Print Patient Name _____

Signature of Patient or Representative _____ Date:_____

Relationship to patient (if other than patient)_____

Witness (Practice Representative)_____