Acknowledgement of Receipt of Notice of Privacy Practices and HIPAA Non-Secure Communication

Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____
Patient Name _____ Date of Birth _____

This form allows Cumberland Trails Family Dental to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used to carry out treatment, payment, or health care options.

Cumberland Trails Family Dental has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing of this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Cumberland Trails Family Dental.

I understand that at anytime I have the right to revoke this consent provided I do so in writing, but Cumberland Trails Family Dental may still use information to complete any actions it began prior to my revoking consent and which rely on my protected health information. I understand Cumberland Trails Family Dental may refuse service if I revoke this consent.

I understand I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided to me in writing. I understand that while Cumberland Trails Family Dental is not required to agree to my requested restrictions, the practice is bound by that agreement if it does agree.

By my signature below I affirm the above information.

Patient Signature _____ Date _____
Parent Signature (if minor) _____ Date _____
Authorized Representative _____ Date _____

_____ Initials I hereby authorize Cumberland Trails Family Dental to use unsecured email and mobile phone text messaging to transmit to me the following protected health information: 1) Information related to the scheduling of appointments; 2) Information related to billing and payment.

_____ Initials I hereby authorize Cumberland Trails Family Dental may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Email _____ Home Phone _____ Office Phone _____ Cellphone

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my health information to any person(s) who accompany me to my appointment and are present with me in the office while I meet with my dentist and staff.

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my personal health information to the person whom I have listed as my emergency contact.

_____ Initials I hereby authorize Cumberland Trails Family Dental may disclose my personal health information to the following person(s):

Name	Phone Number	Relationship to Patient