Management of Private Medical Information

Permit for Release of Medical Information

Patient Name:____.

I do _______ I do not__________ authorize messages containing medical information to be left on my answering machine at phone # _______________________________________.

You may discuss patient's medical information with the following people:

Name_______________________________________ Phone ______________________________

Name_______________________________________ Phone ______________________________

Name_______________________________________ Phone ______________________________

Name_______________________________________ Phone ______________________________

You may______ You may not______ call me______ leave messages______ at my workplace.

Work Phone # (_____)___________-________________

Other requests: ____

____.

I have been given or offered the HIPPA Patient Privacy notice for Custom Dental

Print Name:____ DOB: _____________________

Signature: ____ Date:_____________________

I hereby give my consent for Custom Dental take my photograph. By signing this form, I give Custom Dental permission to use the material gathered to train other doctors within the dental group or include the information and photographs in public marketing pieces only **after verbal consent is given.

____

Signature

Notice of Privacy Practices Acknowledgement

Custom Dental
911 Ridge Pointe Dr
Sapulpa, OK 74066

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ________________________

Relationship to Patient: ________________________

Signature: ________________________

Date: ____________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason