Steven H. Davis, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES -AND- CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Patient's Name:_____ Date of Birth:_____

Daytime Telephone:_____ SS#:_____

SECTION B: TO THE PATIENT—PLEASE READ:

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handling billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that my doctor or his staff can give me called "Revocation of Consent for Use and Disclosure of Health Information"; or
2) Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting my privacy. My doctor may update this "Notice." If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

I authorize the release of information to the following individuals who may participate in my care following surgery:

Name:_____ Relationship to Me:_____

Name:_____ Relationship to Me:_____

* I authorize the information regarding my insurance benefits to be left at my home phone. **Y _____ or N _____.**

My signature below indicates that I have been given a current copy of my doctor's "Notice of Privacy Practices." I understand that I have the right to read the "Notice" before signing this agreement. I have had full opportunity to read and consider the contents of this Acknowledgement and Consent form. I have been given the opportunity to ask any questions I may have regarding this Notice. My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

Patient (or legally authorized individual) signature_____ Date:_____

Relationship to patient (parent, legal guardian, etc.)_____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Patient (or legally authorized individual) signature_____ Date:_____

Relationship to patient (parent, legal guardian, etc.)_____

Patient's Name:_____

Accounting of Protected Health Information Disclosures

Date of Disclosure	Protected Health Information Disclosed	Purpose of the disclosure	To Whom Disclosed (Name/Address)	Date Authorization Signed