Daniel P. Joldersma D.D.S.
Edgewood Dental Care
1010 S. Union St.
Warsaw, IN 46580

HIPAA COMPLIANCE PATIENT CONSENT FORM AND AUTHORIZATION

Our Notice of Privacy Practices provides information about ow we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed this notice before signing this consent.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may then condition receipt of treatment upon execution of this consent.

Patient: _____

May we call/message or email you to confirm appointments?	YES	NO
May we leave a voicemail?	YES	NO
May we discuss your medical condition with anyone other than you?	YES	NO

If yes, please name the person/persons allowed:

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

This consent was signed by: _____

Print Name

Signature: _____ Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Print)

_____ _____
Patient Signature **Date**

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Other:**

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement
__ A communication barrier prevented us from obtaining acknowledgement
__ The individual was unwilling to sign.
__ Other: _____

_____ _____
Staff Member Signature **Date**