ZEELAND FAMILY DENTISTRY

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we have displayed and made available for you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires us to first obtain your written acknowledgement and written consent prior to disclosing any of your information except for our disclosures in connection with; a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Name ______________________________ Date: ______________

Patient Acknowledgement

Please sign to acknowledge that you have been made aware of our Notice of Privacy Practices

I acknowledge that I may receive a copy of the Notice of Privacy Practices.

______________________________ ______________________________

Signature of Patient or Parent/Legal Guardian **Print** Patient or Parent/Legal Guardian Name

Patient Consent

Please sign to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information which you deem necessary in connection with my treatment.

I understand that the law does not require my consent for such disclosures of the type listed above.

______________________________ ______________________________

Signature of Patient or Parent/Legal Guardian **Print** Patient or Parent/Legal Guardian

Patient Special Request

I <u>do</u> <u>not</u> want you to disclose patient information with the person(s) listed below:

- ☐ Parent(s) or Legal Guardian ______________________________
- ☐ Spouse ______________________________
- ☐ Other ______________________________

______________________________ ______________________________

Signature of Patient or Parent/Legal Guardian **Print** Patient or Parent/Legal Guardian