Celebrating Smiles

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Patient Name: ______________________ ______________________ ___ ______________________

Last First MI Preferred Name

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment and health care operations, you must acknowledge that you have read our Notice of Privacy informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to request that we restrict how your Protected Health Information can be used or disclosed for treatment; (2) the right to receive confidential communications of your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

I consent to the release of verbal information regarding my diagnosis/test results/treatment plan to: (Please type name/s or n/a if no one)Do not leave blank. *

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If Other, please describe:

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☐ **I authorize Celebrating Smiles to leave dental information on my voice mail or answering machine.**

☐ ***I acknowledge that I have read the Notice of Privacy Practices concerning the use and disclosure of my Protected Health Information.**

I authorize Celebrating Smiles to use photographs and my name for promotional purposes in any type of display. The photographs and my name may not be used for profit without my express permission. I understand that I will not be paid or rewarded for providing this authorization.
Please check yes or no

* ○ Yes ○ No

Please type name for signature & relationship to Patient (Write "Self" if you are the patient): *

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Response Date: ____________