KENNESTONE DENTAL DESIGNS, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, ______________________, have received a copy of this office's Notice of Privacy Practices.

Print Name ______________________

Signature ______________________

Date ______________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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KENNESTONE DENTAL DESIGNS, LLC

Acknowledgement of Receipt of HIPAA Privacy Policies and Procedures

I, ____, have received and reviewed a copy of Kennestone Dental Designs, LLC's health information privacy and security policies and procedures.

Print Name ____

Signature ____

Date ____

A-10 Patient Consent Form for Use or Disclosure of Patient's Protected Health Information

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KENNESTONE DENTAL DESIGNS, LLC

PATIENT CONSENT FORM FOR USE OR DISCLOSURE OF PATIENT'S PROTECTED HEALTH INFORMATION

This form must be completed by the individual whose protected health information is to be disclosed, or by a parent or guardian if the person is a minor under state law.

Name ____

Date of Birth ______________________________ (for identification purposes)

I hereby authorize (dental practice) to release the following personal health information for: (check all that apply)

☐ Dental services claims information

☐ Prescription, diagnostic, treatment, and/or care management services

☐ Reviews required by HHS or HIPAA-compliant health care operations

☐ Other (specify) ______________________________

The above information may be released by:

☐ Phone ☐ Fax ☐ Mail ☐ Friend or Relative ______________

My Consent

Effective: Today's Date______________________________

I want this consent to:

☐ Continue Indefinitely ☐ Effective Only Until ____________________ (date).

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient ______________________________ Date __________

Or, Personal Representative ______________________________ Date __________