www.arborlakesdental.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Name: ____

How do you want to be addressed when summoned from the reception area:

◊ First Name only ◊ Proper Surname ◊ Other______________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor/facilities.

You may obtain a full copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: 763-494-4443 Fax: 763-420-9139

E-mail: Kristin@arborlakesdental.com

Address: 12000 Elm Creek Boulevard, Suite 230, Maple Grove, MN 55369

Right to Revoke: You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Ability to Communicate: I understand contact from Arbor Lakes Dental to confirm my appointments, treatment & billing information, information about my health, special events and services, and/or new health information may occur via the contact information I provided. I understand I can request preferences to be set up.

SIGNATURE:

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: ____Date: ______________________________

Please list any other parties who can have access to your health information: (This includes step parents, grandparents, parents of children over the age of 18, and any care takers)

Name:____ Relationship:___________________________

Name:____ Relationship: ___________________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Your comments regarding Acknowledgements or Consents: ____

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Office Use Only: ◊ Revoked to sign ________________