ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND HIPAA COMMUNICATION CONSENT FORM

Patient Name:	**Date of Birth:**

This consent form allows Joseph R. Loftus, D.D.S. to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.

Joseph R. Loftus, D.D.S. has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Joseph R. Loftus, D.D.S.

_____ Initial I hereby authorize that Joseph R. Loftus, D.D.S. may leave messages on my voicemail to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

__ cell phone __ home phone __work phone

_____ Initial I hereby authorize that Joseph R. Loftus, D.D.S. may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

_____ Initial I hereby authorize that Joseph R. Loftus, D.D.S. may disclose my personal health information to the person who I have listed as my emergency contact.

_____ Initial I hereby authorize that Joseph R. Loftus, D.D.S. may disclose my personal health information to the following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Joseph R. Loftus, D.D.S. services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Joseph R. Loftus, D.D.S. may refuse service if I revoke this consent.

I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Joseph R. Loftus, D.D.S. is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

By my signature below, I affirm the above information.

Signature of Patient _____ Date: _____

Signature of Parent (if minor) / Authorized Representative _____ Date: _____