# Acknowledgment of receipt of Notice of Privacy Practices



Office name: _____

I received a copy of this office's Notice of Privacy Practices. It explains how the office may use and share my health information and my rights about that information.

Patient name: _____ Date of birth: _____ Phone: _____

_____ _____

Signature of patient or personal representative | Date

_____ _____

Name of personal representative (print), if signing for the patient | Relationship or authority to act for the patient

**For the office: if the acknowledgment was not signed**

Required by 45 CFR 164.520(c)(2)(ii) when no signature is obtained, except in an emergency treatment situation.

- ☐ Patient was given the notice but declined to sign
- ☐ Patient could not sign. Reason:
- ☐ Emergency treatment situation. Notice to be given as soon as reasonably practicable after the emergency
- ☐ Other good faith effort and reason:

_____ _____

Staff name and signature | Date

Give the notice no later than the first visit, post it in a clear and prominent place in the office, and post it on your website if you have one (45 CFR 164.520(c)). Keep signed acknowledgments, or the record of your good faith effort, for 6 years (45 CFR 164.530(j)).

# Authorization to use or disclose health information

complyday.com

Patient name: Date of birth: Phone:

### 1. Information to be used or disclosed

- ☐ Complete dental record
- ☐ X-rays and images
- ☐ Treatment notes from (date) _____ to (date) _____
- ☐ Billing and payment records
- ☐ Other (describe):

### 2. Who may disclose it

Office name: Address:

### 3. Who may receive it

Name or organization: Address: Phone, fax or email:

### 4. Purpose

- ☐ At my request
- ☐ Other (describe):

### 5. This authorization ends

On this date: Or when this event happens:

### Your rights

You may revoke this authorization at any time by giving the office written notice at the address above. Revoking it does not undo any use or disclosure the office already made in reliance on it.

The office will not condition your treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

Information disclosed under this authorization may be redisclosed by the person who receives it and may no longer be protected by federal privacy rules.

You will receive a copy of this signed form.

Signature of patient or personal representative

Date

Name of personal representative (print), if signing for the patient

Description of the representative's authority to act for the patient

Core elements and required statements: 45 CFR 164.508(c). Not needed for treatment, payment or health care operations, such as sending records to a specialist for treatment. Keep for 6 years (45 CFR 164.508(b)(6), 164.530(j)).

# Request to inspect or get a copy of dental records

complyday.com

Patient name: Date of birth: Phone:

Mailing address: Email:

### Records requested

- ☐ Complete dental record
- ☐ X-rays and images
- ☐ Records from (date) _____ to (date) _____
- ☐ Billing records
- ☐ Other:

### How I want to receive them

- ☐ Inspect them at the office
- ☐ Paper copy, picked up
- ☐ Paper copy, mailed to the address above
- ☐ Electronic copy (format, if any): _____
- ☐ Email to the address above. I understand regular email may not be secure

### Send a copy directly to another person (optional)

Name: Address or email:

Signature of patient or personal representative

Date

### For the office

Date request received

Respond by (no later than 30 days after receipt)

Extension notice sent, with reason and new date (one extension of up to 30 days)

Date provided, and fee charged, if any

Rules: 45 CFR 164.524. You may require written requests if you tell patients in advance. A request to send records to another person must be in writing, signed, and name the person and where to send them. Any fee must be reasonable and cost-based, covering only labor for copying, supplies, postage and, if the patient agrees, preparing a summary.

# Request for confidential communications

complyday.com

Patient name: Date of birth: Phone:

I ask the office to contact me about appointments, treatment and bills only in the ways I mark below. I do not have to give a reason.

**Phone**

- ☐ Call me only at this number: _____
- ☐ You may leave a detailed message
- ☐ Leave only your name and number
- ☐ Do not leave a message
- ☐ Texts are OK at this number

**Mail and email**

- ☐ Send mail only to this address: _____
- ☐ Email only to this address: _____
- ☐ Do not email me

**Bills**

Send bills to (if different):

Signature of patient or personal representative

Date

**For the office**

Date received

Entered in the patient's record by

Rules: 45 CFR 164.522(b). A dental office must accommodate reasonable requests and may ask for them in writing, but may not require the patient to explain why. It may ask for an alternative address or contact method and how payment will be handled.

# Request to restrict use or disclosure of health information

complyday.com

Patient name: Date of birth: Phone:

**What I want restricted**

Information: Not to be shared with:

☐ Do not send information about the service(s) below to my health plan. I have paid, or will pay, for them in full myself.

Service(s) and date(s):

Signature of patient or personal representative Date

**For the office**

☐ Agreed

☐ Not agreed. Patient told on (date):

☐ Paid in full, health plan restriction. Must be agreed unless the disclosure is required by law

Staff name and signature Date

Rules: 45 CFR 164.522(a). An office does not have to agree to most restriction requests, but once it agrees it must follow the restriction except in an emergency. It must agree not to send a health plan information about a service the patient, or someone other than the plan, paid for in full, when the disclosure is for payment or operations and not required by law. Document agreed restrictions and keep them for 6 years.

# People the office may talk to about my care

complyday.com

Patient name: Date of birth: Phone:

The office may share information directly related to my dental care or bills with the people listed below.

| Name | Relationship | Phone | What may be shared (appointments, treatment, bills) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Signature of patient or personal representative

Date

Optional. HIPAA does not require a written form for this. Under 45 CFR 164.510(b), you may share information relevant to a person's involvement in the patient's care or payment if the patient agrees or does not object when given the chance. A written list makes the patient's choice easy for every staff member to check.