PACIFIC DENTAL CARE

Lancaster	Palmdale East	Palmdale West	Rosamond
1790 east Ave J	37262 47th St. E. ste 101	39522 10th St. W. ste C	2535 Rosamond Blvd ste B
Lancaster, CA 93535	Palmdale, CA 93552	Palmdale, CA 93551	Rosamond, CA 93560
(661) 948-8187	(661)285-8600	(661) 267-5700	(661) 256-2500
Fax (661) 948-1134	Fax (661) 285-2048	Fax (661) 267-0103	Fax (661) 256-7561

HIPAA Privacy Rule Individual Consent Acknowledgement Agreement

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS [§164.506(a)]
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE [§164.520(a)]

I, ____ acknowledge that I have been provided with and understand Pacific Dental Care/Dental Group's **Notice of Privacy Practices**, describing the uses and disclosures of my protected health information.
I understand that it is part of my health care, Pacific Dental Care/Dental Group originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and dental information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I request the following restrictions to the use or disclosure of my health information:
«Insert any additional patient specific requirements to be included»

I understand that:

- I have reviewed Pacific Dental Care/Dental Group's Notice of Privacy Practices prior to signing this consent;
- That Pacific Dental Care/Dental Group reserves the right to change his notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Pacific Dental Care/Dental Group is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Pacific Dental Care/Dental Group has already taken action in reliance thereon;

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HIPAA Privacy Rule Individual Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment or Healthcare Operations (§164.508(a))

I,_________________________________ understand that as part of my health care, Pacific Dental Care/Dental Group originates and maintains health records describing my health history, symtoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with and understand that Pacific Dental Care/Dental Group's *Notice of Privacy Practices* provides a more complete description of the information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review Pacific Dental Care/Dental Group's Notice of Privacy Practices prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PHI Authorized:

Purpose Authorized:

Parties to whom my PHI is authorized to be released:

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations by other covered entities;
- I may revoke this consent in writing at any time, except to the extent that Pacific Dental Care/Dental Group has already taken action in reliance thereon.

[] Accepted [] Denied

Signature of Individual or Legal Representative Witness_______________________________

Printed Name of Individual or Legal Representative Witness____________________________

Date___________________________

HIPAA Privacy Rule Individual Consent and Acknowledgement Agreement

Pacific Dental Care

I acknowledge and accept the patient contact procedures of Pacific Dental Care/Dental Group that:

- I will respect the requirements that Pacific Dental Care/Dental Group must meet in accordance with the HIPAA Privacy Rule;
- I will be contacted by Pacific Dental Care/Dental Group 24 hours before my appointment;
- I can be contacted on the telephone numbers listed on Pacific Dental Care/Dental Group Information Sheet and you **may/may not** leave message for me;
- If I cannot be contacted personally I authorize you to discuss my dental condition with the following people:

NAME	RELATIONSHIP	CONTACT #	DATE	CANCELLED DATE

Signature of Individual or Legal Representative____

Printed Name of Individual or Legal Representative______________________________________

Date___________________________________