ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Private Practices: You have the right to read our Privacy Practices before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Kari Mann DDS PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Kari Mann DDS PLLC reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY OR CLOSE RELATIONS

In addition to the allowable disclosures described in the statement of privacy practices, I hereby specifically authorize disclosure of my Protected Health Care information to the person(s) identified below. I understand that unless I identify specific persons below, personal protected information cannot be shared or discussed with anyone unless otherwise allowed by HIPAA rules.

Spouse (Name) ____ ○ Yes ○ No
Any member of my immediate family: (i.e. Spouse, Children, Siblings, etc.) ○ Yes ○ No
Any member of my extended family: (i.e. Parents, Grandchildren, etc.) ○ Yes ○ No
Other (Name) _________________________________ Relationship ___________________ ○ Yes ○ No

Unless otherwise instructed we will contact you regarding appointments and billing at the number(s), email(s), and addresses provided. We may leave messages or texts on those devices.

Patient's Name: ____

Signature: ____ Date: _____________
(Patient or Parent/Legal Guardian)

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

Parent/Legal Guardian Name______________________________Relationship to Patient: ________________________