HIPPA: Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name (Print):___________________________

I have received a copy of this office's Notice of Privacy Practices. This notice contains the information that federal law requires us to disclose about our privacy practices:

Patient Signature: X___________________________ Date:_____________________________

Michigan Law-Patient Consent

In addition to the Acknowledgement of Receipt required by federal Law, Michigan Law requires us to obtain your written consent prior to disclosing your information, except in certain circumstances. From time to time, it may be neccesary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or send your models to a dental laboratory to create a dental appliance.

I consent to this office's disclosures of my information that it deems are necessary in connection with my treatment.

Patient Signature: _______________________ Date:______________________

Authorization for Release of Personal & Health Information

Patient Name:_________________________(Print Name)

I request and authorize Randall W. Chambers,D.D.S.,PC to release my personal and health information that the practive has which may include claims and billing inofrmation and medical records.

A. Information that may be disclosed (choose one):
   __All personal andhealth information contained in my dental record AND all claims and billing information
   __All personal and health information contained in my dental records ONLY
   __All claims and billing information ONLY
   __Other (sucha as information relating to a specfic date of service or a specfic issue)
   ____
B. Disclosure is to be made to (name of person or entity):
   ____
C. Purpose of the Discloure: ___At the request of the individual __Other
D. This authorization expires (choose one): __On the following Date:_____________
   __Upon the following Event:__________

I understand that I may revoke this authorization at any time, but I must do so in writing to Randall W. Chambers, D.D.S.,PC. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information to others without my knowledge or consent and therefore the privacy of my personal and health information may no longer be protected by law.

Signature:____________________________ Date:______________________________

If signed by a person other than the patient, please check the relationship and authority to do so:

__Parent of Minor Child __ Power of Attorney __Legal Guardian