## Bruce P. Mitchell, D.M.D., P.C.

## HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND AUTHORIZATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to provide you with our Notice of Privacy Practices, which explains our privacy practices and how we may legally use and disclose your Protected Health Information. In order to protect your privacy and confidentiality, we ask that you authorize when, and to whom, protected health information can be released.

| May we leave a deta<br>Yes No                 | ailed message on your answering machine/voicemail?   |                            |
|---|--|----------------------------|
| May we call you at v<br>Yes No                | work and leave a message to call the office back?  |                            |
| When available, may<br>Yes No                 | y we send you a text (SMS) message?  |                            |
| When available, may<br>Yes No                 | y we send you an e-mail message?   |                            |
| members or other in                           | rmission to talk and allow access to your Protected Health Information and individuals? Yes No provide the name and relationship of the authorized individuals:              | to family                  |
| Name:   |  |                            |
| Name:   | Relationship:  |                            |
| Name:   |  |                            |
|   |  |                            |
| Notice of Privacy Pra                         | I acknowledge that I have received a copy of the Bruce P. Mitchell, D.Nactices and have been given an opportunity to ask questions. A copy of my chart for future reference. | 1.D., P.C.<br>this consent |
| Notice of Privacy Pra<br>will be scanned into | actices and have been given an opportunity to ask questions. A copy of   | this consent               |