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 detailed message on your answering machine/voicemail?
Yes No

May we call you at work and leave a message to call the office back?
Yes No

When available, may we send you a text (SMS) message?
Yes No

When available, may we send you an e-mail message?
Yes No

Do we have your permission to talk and allow access to your Protected Health Information to family members or other individuals? Yes No

If yes, please provide the name and relationship of the authorized individuals:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

By signing this form, I acknowledge that I have received a copy of the Bruce P. Mitchell, D.M.D., P.C. Notice of Privacy Practices and have been given an opportunity to ask questions. A copy of this consent will be scanned into my chart for future reference.

Patient Signature:_____Date:_____/_____/_____

Relationship (if other than patient):_____