

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge receipt of the Privacy Practices of Contra Costa Endodontics and acknowledge that I have had the opportunity to read this description of their privacy practices and ask questions regarding their privacy practice.

Dated:

Signature of Patient

Print Patient's Name

The patient, _____, was provided a copy of this Acknowledgement of Receipt of Privacy Practices and has either been unable to sign, or has refused to sign it.

Dated:

Privacy Officer/Contact Person

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Having read and understood the Privacy Practices of Contra Costa Endodontics, I hereby consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I understand that I am not required to give this consent in order for Contra Costa Endodontics to use my protected health information for treatment, payment activities and health care operations. I also understand that I may revoke this consent in writing by submitting the revocation to the Privacy Officer/Contact Person listed in Contra Costa Endodontics Privacy Practices notice. I further understand that if I decline to give my consent or if I revoke it, Contra Costa Endodontics may refuse to treat me or proceed with treatment, payment activities and health care activities as if consent was given or not revoked.

Dated:

Signature of Patient

Print Patient's Name

The patient, _____, was provided a copy of this Consent to Use and Disclose Protected Health Information and has either been unable to sign or refused to sign it.

Dated:

Privacy Officer/Contact Person

REVOCACTION OF CONSENT

I hereby revoke the consent for Contra Costa Endodontics to use my protected health information, which I gave on ____/____/_____. I understand that Contra Costa Endodontics may refuse to treat me or may proceed with treatment payment activities and health care operations as if this revocation was not made.

Dated:

Signature of Patient

Note: Keep copy of this document in patient's chart and office HIPAA file.