Darren M. Chugg, D.M.D. 6120 W. Bell Road, Suite 170 Glendale, Arizona 85308 (623) 487-1122

HIPAA ACKNOWLEDGEMENT & CONSENT FORM

Updated 3/3/2023

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practice by initialing here _________.

Our Notice of Privacy Practice states that we reserve the right to change the terms described. Should this happen, we will issue a revised Notice of Privacy Practice containing the changes.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, and health care operations. We are not required to agree to your restrictions. If we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

Patient Signature: ______________________________________ Date: _________/_________/_________

Name of Patient (please print): ____

Address: ____ City_______________ State______ Zipcode________

Phone Number: (   )____________________

If this Consent is being signed by a personal representative of the patient(s), provide the following information (please print):

Personal Representative's Name: ____

Relationship to and Name of Patient: ____

You are entitled to a copy of this Acknowledgement and Consent after you sign it.

<u>For Office Use Only</u>

Acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgments
- ☐ An emergency situation prevented us from obtaining acknowledgements
- ☐ Other (Please Specify): ____

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HIPAA - RELEASE OF INFORMATION AUTHORIZATION FORM

In compliance with federal and state law, the release of information for any person 18 years or older (including the information regarding a spouse or adult child), **must first be authorized**. Authorization includes the signature of the individual authorizing the release of their information. Information **will not be available** to anyone other than the covered patient (i.e. a member, a spouse, or any dependent age 18 or older) without first having this Release of Information Authorization on file. For example, if a subscriber calls about the status for a claim on a 19-year old dependent, that information will not be given to the subscriber without the written consent of the dependent. The same situation holds true for spouse-to-spouse information. However, parents do have a right to information on children under the age of 18 without the child's consent.

I **do not** want to provide the authorization: ☐
Name of Patient: ________________________________ Patient/Guardian Signature: ____________________________
Date of Birth of Patient: _________/_________/_________ Date: _________/_________/_________

I **want** to provide the authorization: ☐
Name of Patient Authorizing Release: ____
Date of Birth of Patient Authorizing Release: _________/_________/_________

The following is an authorization allowing Paseo Family Dental & Dentures to release information to whomever you designate. Paseo Family Dental & Dentures is authorized to make the disclosure of my dental treatment, dental records, dental treatment history, prescription information, benefits information, claim(s) status, claim(s) history, general claim information, dentist information, lab cases, and enrollment information, unless otherwise specified to the following individual(s) or organization(s):

Name of Person/Organization that the office may release my information to: _______________________________
Relation of Person/Organization: ____
Phone Number: (   )_____________________

Name of Person/Organization that the office may release my information to: _______________________________
Relation of Person/Organization: ____
Phone Number: (   )_____________________

Name of Person/Organization that the office may release my information to: _______________________________
Relation of Person/Organization: ____
Phone Number: (   )_____________________

AUTHORIZATION CONSENT

I understand that consent may be revoked by me at any time in writing. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Patient/Guardian Signature: _____________________________________ Date: _________/_________/_________