Simply Southern Smiles

HIPAA – PATIENT ACKNOWLEDGE USE AND DISCLOSURE FORM

* You May Refuse to Sign This Acknowledgement. *

Our Notice of Privacy Practices provides information about how Simply Southern Smiles may use and disclose protected health information about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The Notice of Privacy contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that Simply Southern Smiles may use and disclose PHI about you for treatment, payment, and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or healthcare operations.

I have received a copy or was offered a copy and declined, of this office's Notice of Privacy Practices.

_____ _____
Name of Patient Date of Birth

_____ _____
Signature (Patient/Legal Guardian) Date

I give permission for Simply Southern Smiles to:

Leave a message by phone, email or text concerning:
_____ a call back/contact information only _____ appointment information
_____ billing/financial/insurance information

Share information concerning my treatment with:

_____ _____ _____
Name Relationship Phone #

_____ _____ _____
Name Relationship Phone #

I assume responsibility to inform the practice of any changes in the above information.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Signature (Patient/Legal Guardian) Date