HOMETOWN FAMILY DENTISTRY

Patient Name: _____ **Birth Date:** _____

Parent or Guardian: _____ **Today's Date:** _____

Acknowledgement of Receipt of Notice of Privacy Practices & HIPPA Privacy Policies and Procedures

I have received a copy of this office's:

____ Notice of Privacy Practices

____ HIPPA Privacy Policies and Procedures

Signature: _____ **Today's Date:** _____

Patient Consent for Electronic Communication

If you provide us with your email address, you are able to take advantage of our practice's electronic services, including appointment conformation and electronic delivery of any requested information abut account details. By utilizing our practice's electronic services, you agree that Hometown Family Dentistry may send to you any relevant information through the internet to the email address that you designate.

Please check the you understand that:

_____ All electronic communication from our practice will be encrypted.

_____ I am responsible for providing the dental practice any updates to my email address.

_____ I am able to receive information electronically and store it securely away from any public computer(s).

_____ You can remove your email address from our system at anytime by calling our office at 706-387-0305

Email address: _____

Signature: _____ **Today's Date:** _____

Patient Consent for Use of Disclosure of Patient's Protected Health Information (PHI)

Choose One of the following options:

I authorize Hometown Family Dentistry to release relevant personal information by phone, fax or mail for:

_____ Dental services claim and information

_____ Prescription, diagnostic, treatment and/or care management services

_____ Reviews required by HHS or HIPPA-compliant care operations

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

PHI may also be released to the following people (friend or relative): _____

OR

I refuse to permit use and disclose of my protected health information and will be filing all dental insurance claims myself:

Signature: _____ **Today's Date:** _____