PEMBROKE PINES DENTAL HEALTH CENTER

1806 N Flamingo Rd., Suite 170, Pembroke Pines, FL 33028

HIPAA

PATIENT ACKNOLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF PEMBROKE PINES DENTAL HEALTH CENTER NOTICE OF PRIVACY PRACTICES.

With my consent **PEMBROKE PINES DENTAL HEALTH CENTER may** use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **PEMBROKE PINES DENTAL HEALTH CENTER Notice** of Privacy Practices for a more complete description of such uses and disclosures. **PEMBROKE PINES DENTAL HEALTH CENTER reserves** the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **PEMBROKE PINES DENTAL HEALTH CENTER, 1806 N Flamingo Rd., Suite 170, Pembroke Pines, FL 33028**

With my consent, **PEMBROKE PINES DENTAL HEALTH CENTER** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. **I understand that I have the right to request a restriction on how my information is divulged or mailed, should I wish to exercise this right I understand I need to request it in writing.**

With my consent, **PEMBROKE PINES DENTAL HEALTH CENTER** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **I also understand that I have a right to restrict and limit where my information is sent, should I wish to exercise my right I understand I need to request it in writing.**

I understand that I can request in writing under a separate form, for my medical records to be e-mailed or faxed by PEMBROKE PINES DENTAL HEALTH CENTER and that there is potential that this information may reach unintended parties or that the security of these transmissions may be breached in transit. I have the right to request that PEMBROKE PINES DENTAL HEALTH CENTER restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

By signing this form, I am consenting to **PEMBROKE PINES DENTAL HEALTH CENTER use** and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **PEMBROKE PINES DENTAL HEALTH CENTER may** decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

Good faith attempt to obtain the signature from the patient. Describe the reason why patient did not sign the form:

_____
_____

_____ _____

SIGNATURE OF THE STAFF MEMBER DATE