HIPAA – Personal Care Dental Group

Disclaimer

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence. It is my responsibility to inform this office of any changes in my personal or medical information. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date: _____

Privacy Practices

PERSONAL CARE DENTAL GROUP, LLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

you may refuse to sign this acknowledgement

I, _____, understand that Personal Care Dental Group, LLC abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name _____

Signature _____ Date _____

TO DISCLOSE PRIVATE INFORMATION TO PERSONS OTHER THAN THE PATIENT:

I, _____, give permission to Personal Care Dental Group to discuss my patient and account information with the following:

_____ _____

Name Relationship

_____ _____

Name Relationship

Signature _____ Date_____

Release for Use of Photographs

I, _____ (patient name), hereby give Personal Care Dental Group the right and permission, with respect to the photographs and models that have been taken of me to be used and republished for further patient demonstration and education. I understand any use of these items will be done with complete anonymity.

I have read the above and fully understand the terms of this release.

Patient Name (please print): _____

Signature: _____ Date: _____