HIPAA PRIVACY FORM
SUSAN ION HOGAN, D.D.S, P.A.
27 BARKLEY CIRCLE, FT. MYERS, FL 33907

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME:_____

ADDRESS:_____**CITY:**_____**ZIP**_____

TELEPHONE_____**E-MAIL**_____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLWING STATEMENTS CAREFULLY:
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices
Including any revisions of our Notice, at any time by contacting:
Susan Hogan Tel: 239-939-3332 Fax: 239-939-7712
27 Barkley Circle, Ft. Myers, FL 33907

LIST FAMILY/FRIENDS YOU CONSENT TO TO DISCLOSE YOUR DENTAL RECORDS:
_____
_____

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will ***not*** affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____**Date**_____ **over>>>>>>>**

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representatives Name:_____Relationship to Pt._____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received This written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent

Signature:_____Date:_____

AKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining the acknowledgement

□ Other (Please Specify)

_____
_____
_____
_____