HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****
A copy of the Notice of Privacy Practices is at the front desk and available to you upon request.

The purpose of this form in layman's terms is- ***we want to know how you wish to be contacted about appointments and who, if anyone, (a spouse, family member, significant other, etc.), can inquire about when and what time your appointment is scheduled or details about an appointment. If their name is not on your HIPAA form, we cannot give them that information.***

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.
I acknowledge and allow Mount Auburn Dental to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] No information is to be released to anyone. (**This includes dental claims**) Ins. Only _____

Telephone Messages:
The best time to reach me personally is (day) _____ between (time) _____
Please call: [ ] my home phone [ ] my work number [ ] my cell number
_____ _____ _____
If unable to reach me:
[ ] you may leave a detailed message [ ] please leave me a message asking for a return call
*If you require pre-medication before your dental appointment may we remind you if leaving a message? Y N

Is there a specific day(s) and time(s) best to schedule appointments? _____
Everyone would like an 8:00am or 4:00pm appointment, if you are able to do another time we would appreciate it.

Are there any changes to insurance? Give card to front desk to copy!!

Agreement to Receive Electronic Communication
I agree that Mount Auburn Dental may communicate with me electronically at the email address below, including text messages to my cell phone number.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.

I am responsible for providing Mount Auburn Dental any updates to my email address and cell phone number.
Email Address (PLEASE PRINT CLEARLY):
_____@_____
I can withdraw my consent to electronic communications by calling 207-782-3971 and ask the business team to discontinue this type of communication immediately.
( ) **I prefer not to have electronic communications**
May we use your kind survey comments/photo in our advertising efforts? __Y __N Can we use your name? __Y __N
_____

Patient Signature:_____ Date: _____
This **Release of Information** will remain in effect for one year or until terminated by me in writing.