{STEPHEN M. PALMER DDS PC}

ACKNOWLEDGEMENT 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 acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Consent for Use Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policy, please contact:

The Office at 1-928-333-2345, P.O. Box 1090, Eagar, AZ 85925.

Patient's Consent

Name: _____ D.O.B. _____

Social Security #: _____ Telephone: (_____) _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail: _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purpose of healthcare operations, treatment and payment activities.

Signature: _____ Date: _____

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

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Name: _____ Relationship to Patient: _____

Patient's Revocation

By signing below, you revoke your consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ Date: _____

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

Responsible Party Name: _____ Relationship to Patient: _____