



DR. JEFF KNUTZEN
Excellence in Family & Cosmetic Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996

<http://www.hhs.gov/ocr/hipaa/finalreg.html>

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name of Patient: _____
Address: _____
Telephone: _____ E-mail: _____
Social Security #: _____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING 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 decide 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:
Jeff Knutzen, D.D.S., 2020 Cassia Road, Suite 101, Carlsbad, CA. 92009. (760) 438-8353.

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 received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

****Acknowledgement of Receipt and Consent:**

I, _____, have received acknowledgement of this office's Notice of Privacy Practices and agree to them.
Print Name

June 30, 2016

SIGNATURE PATIENT/PARENT

If a personal representative on behalf of the patient signs this Consent, complete the following:

****Personal Representative's Name:** _____ **Relationship to Patient:** _____

****Please list** any family members or friends that we may discuss your dental needs, treatment and/or financial, with:

Acknowledgement of Receipt and Revocation of Consent:

I, _____, revoke my consent for your use and disclosure of my protected health information for treatment, _____
Print Name
payment activities, specialty referrals, 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.

June 30, 2016

SIGNATURE PATIENT/PARENT

For Office Use:

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) _____