ACKNOWLEDGEMENT OF RECEIPT OF HIPAA POLICIES AND PROCEDURES

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

PERSONAL HEALTH INFORMATION DISCLOSURE AGREEMENT FOR EAST COBB ORTHODONTICS

I, _____, do hereby grant permission for East Cobb Orthodontics, to disclose my personal health information to the following personal representative(s): (spouse, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- o Appointment dates and times
- o Treatment plans and referrals
- o Financial and billing information
- o Any other pertinent dental health information related to treatment at this office.
- o None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to East Cobb Orthodontics.

_____ _____

Patient Signature Date

_____

Patient's Date of Birth

_____ _____

Witness Signature Date