ORCHARD PARK FAMILY DENTISTRY
1843 IDA RED ROAD, KENDALLVILLE, IN 46755

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and been given the option to receive a copy of Orchard Park Family Dentistry's Notice of Privacy Practices.

Printed Patient Name: _____
Patient/Guardian Signature: _____
Date: _____

HIPAA CONSENT

I agree to allow Orchard Park Family Dentistry to discuss and/or disclose my Personal Health Information *(PHI)* via: (Please check **all allowed** methods)

- Text Message. Preferred Text Phone Number: _____
- Email. Preferred Email Address: _____
- Voicemail/answering machine. Preferred Phone Number: _____
- Fax. Preferred Fax Number: _____

I agree to allow Orchard Park Family Dentistry to discuss and/or disclose my Personal Health Information *(PHI)* with the following:

NAME	**PHONE NUMBER**	**RELATIONSHIP**

☐ By checking here, I acknowledge that I wish for my Personal Health Information *(PHI)* to **not** be discussed/disclosed with ***anyone but myself*** at this time. I understand I can update this at any time.

I understand that this consent is in effect until updated and/or terminated in writing.

I authorize Orchard Park Family Dentistry to discuss/disclose my *PHI* to emergency medical personnel or first responders as necessary to ensure my health and safety in the event of a medical emergency.

I understand that my *PHI* could include, but is not limited to, information associated to insurance and billing, appointments, test results, radiographs and treatment (either completed and/or needed).

Printed Patient Name: _____
Patient/Guardian 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) _____